January 1958 ★ VOLUME 54 ★ NUMBER 1

The Ohio State MEDICAL JOURNAL

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The Ohio State Medical Journal

Vol. 54 January, 1958 No. 1

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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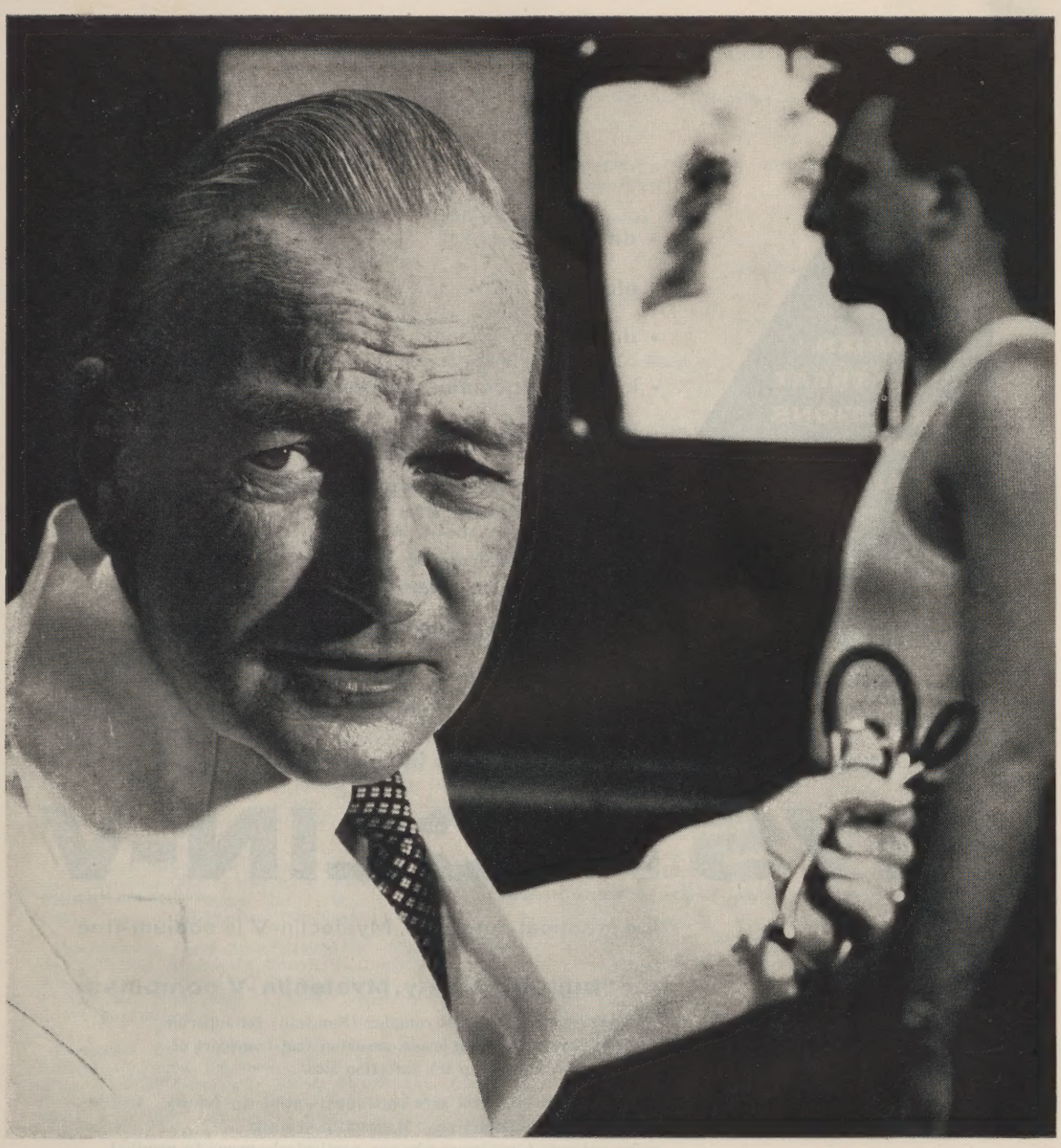
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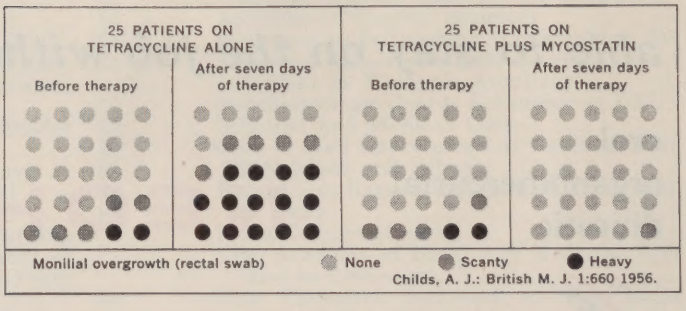
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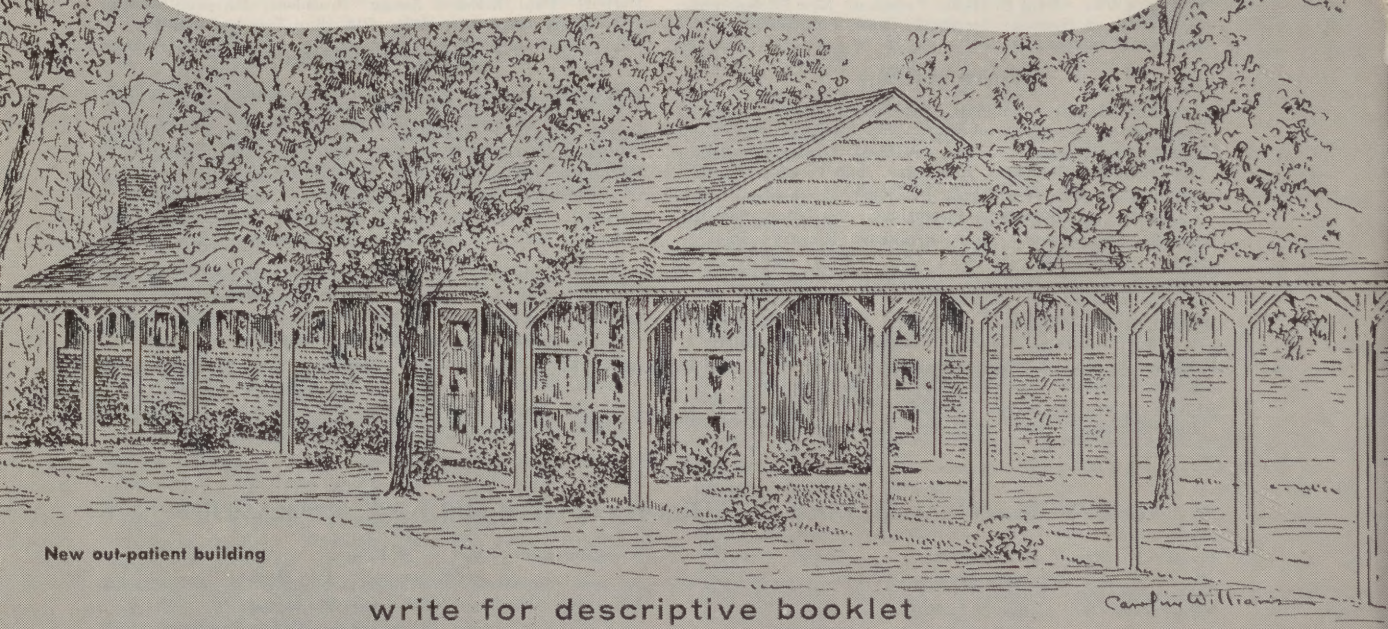
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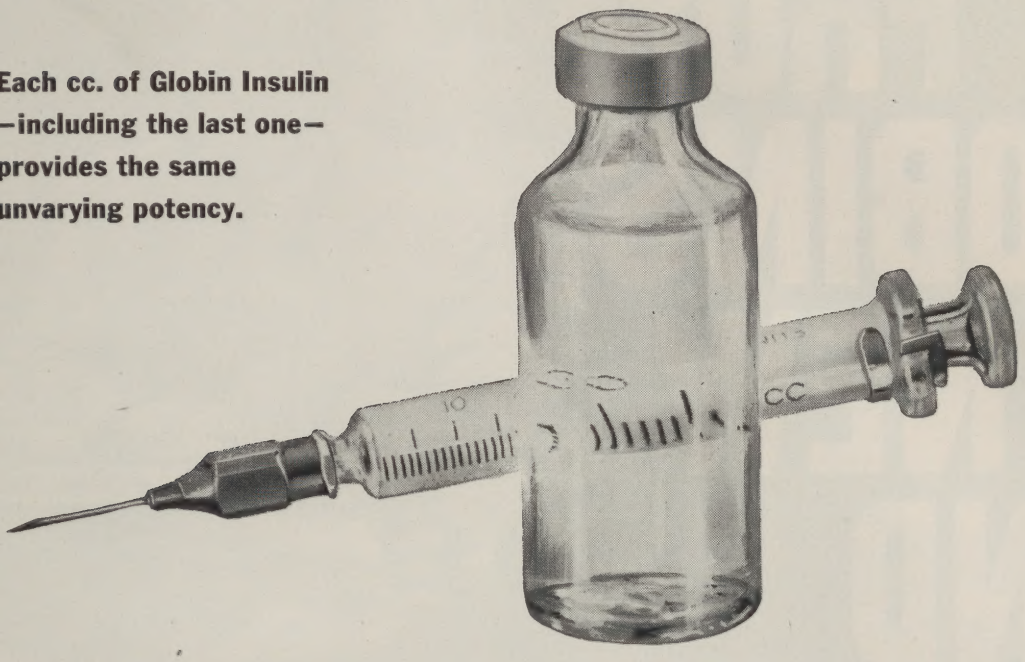
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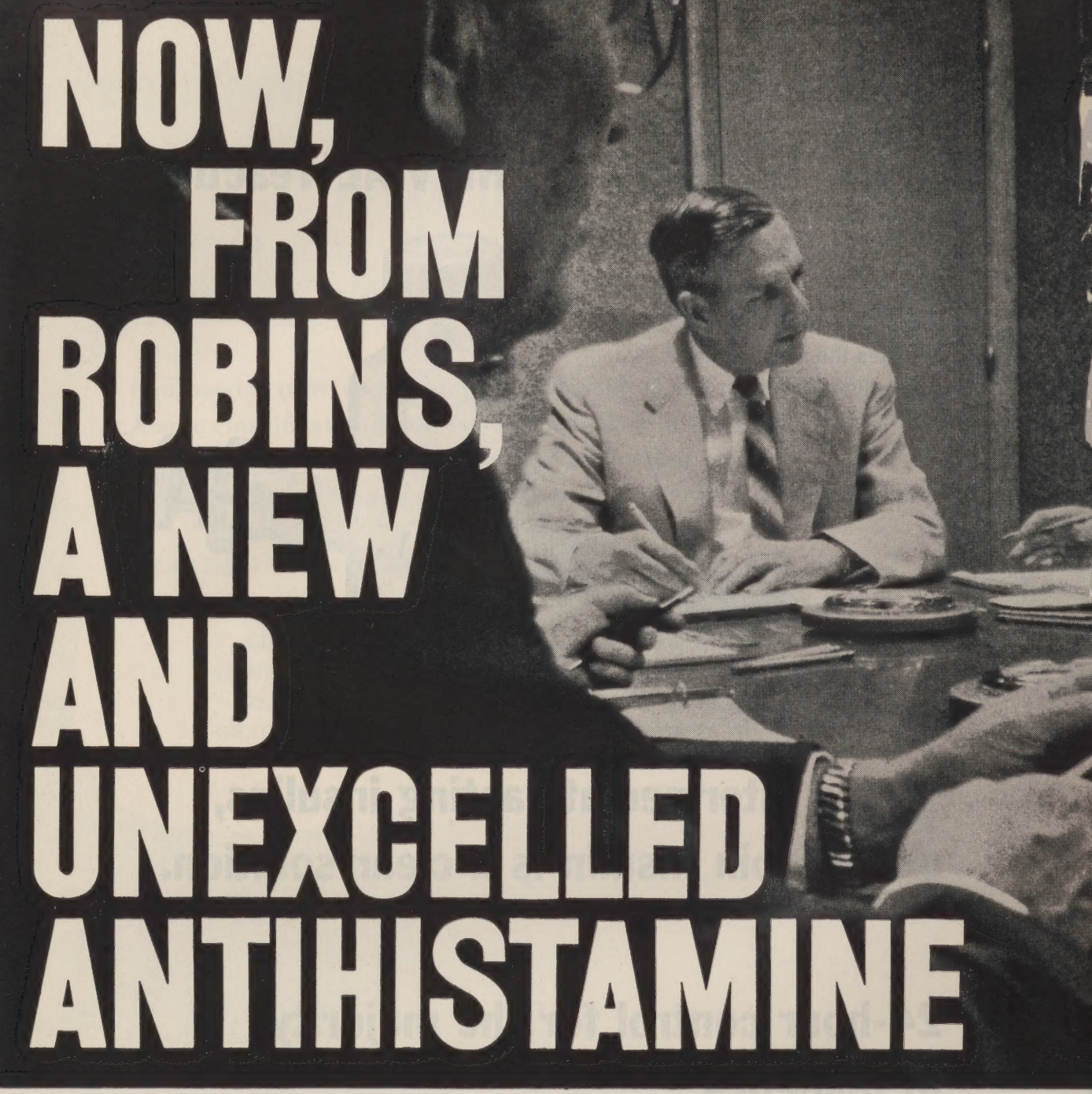
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Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as completed.



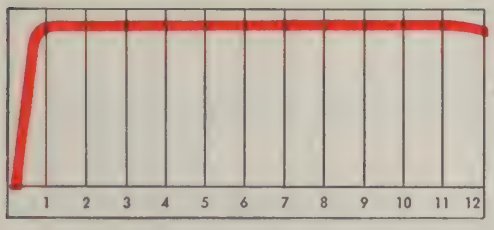
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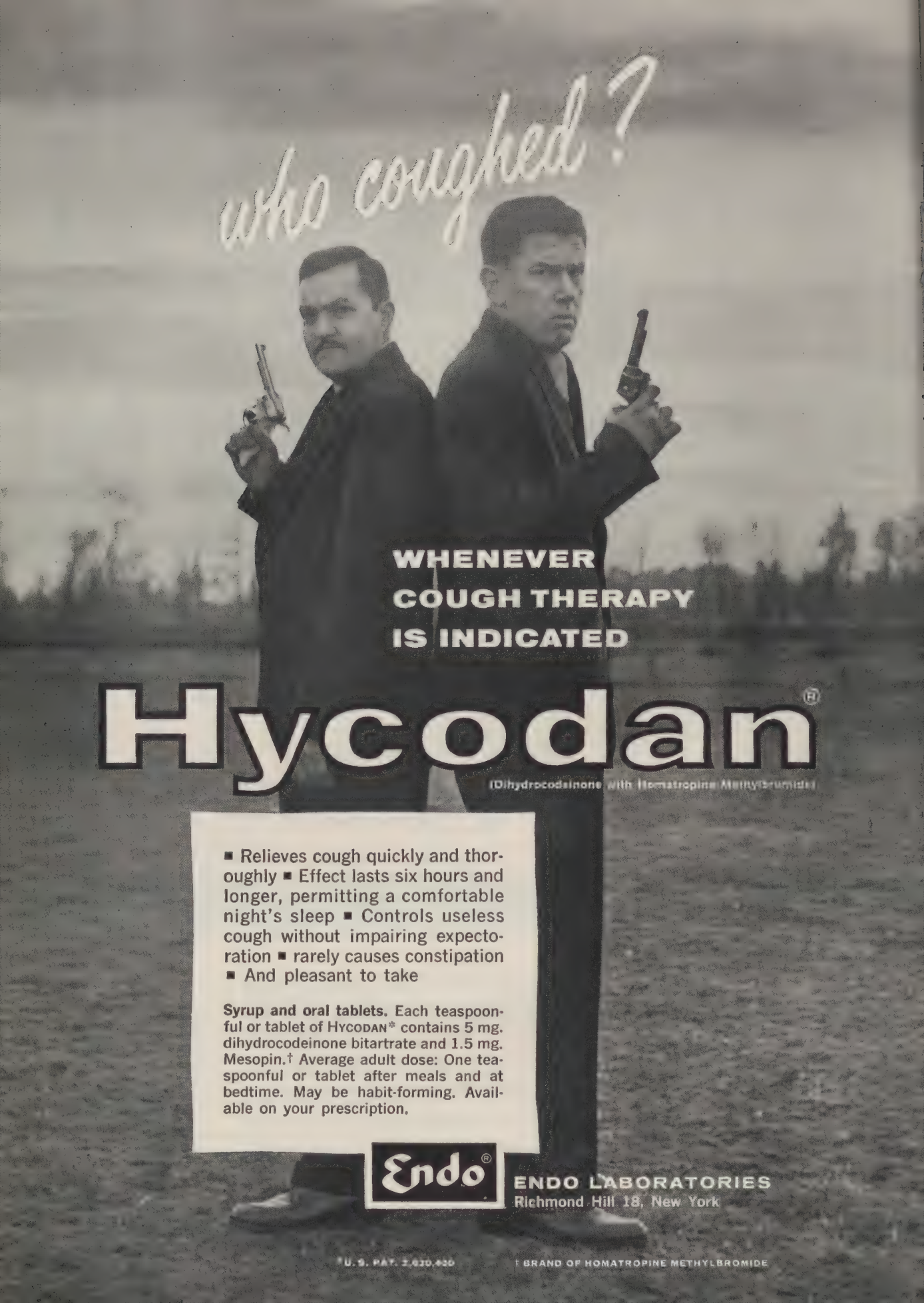
Dosage:

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One Extentab q.8-12 h. or twice daily.
Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.
Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Federal medical-health spending for fiscal year ending June 30 may reach more than $2,500,000,000 as that is the amount appropriated for 23 departments and agencies. Biggest item is $849,395,800 for Department of Health, Education and Welfare, followed closely by VA appropriation of $849,374,000.

* * *

The "big push" to catch up with Russia's scientists involves medicine in two aspects: (1) Eisenhower has said Congress faces task of cutting out programs "not absolutely essential," meaning that federal medical programs "not absolutely essential" will be under close scrutiny, and (2) if any broad program of scholarships is eventually offered, medical studies will not be ignored.

* * *

Public Health Service has completed allocation of 60 million dollars voted for laboratory research facilities, with recipients matching that amount. Applications for grants far exceeded amount of money available. The facilities are for research in cancer, heart disease, mental illness and other diseases.

* * *

National Health Survey has produced statistics indicating that 45 million Americans under 40 years of age still have not received Salk vaccine, while approximately 34 million have received three shots.

* * *

A new report from the National Science Foundation calls for stepped up research in science, including medicine, but advocates more money be sought from non-government sources rather than seek additional Federal funds. The Foundation said this could be encouraged by changing internal revenue laws.

* * *

Social Security Administration research shows fewer people receiving old age assistance payments, but the total amount spent on this program continues to increase. Latest figures show assistance payments to 167 out of each 1,000 old people, compared with 226 per 1,000 in 1950. Steady drop in individuals on OAA is attributed to expanded Social Security coverage.

* * *

State and Territorial Health Officers' 1957 annual conference endorsed five-year extension of Hill-Burton program and AMA proposal of local committees on problems of the aged within medical societies.

Health Information Foundation reports that accidents, despite much progress in their prevention, continue to be the fourth leading cause of death in the U. S. Report stated that while the annual figure has remained fairly constant at about 100,000 since 1932, death rates per 100,000 population have dropped 40 per cent in the last half century.

* * *

Communicable Disease Center, USPHS, has collected data showing 5,805 polio cases during first 48 weeks of 1957, compared with 15,036 for that period in 1956 and 28,842 in 1955.

* * *

Atomic Energy Commission has lowered permissible radiation exposure level. Limit of 15 rems in one year is retained but average over a period of years may not now exceed five rems per year. For example, employee in a sensitive area may not receive more than 150 rems in 30 years, compared with 450 rems under the old limit.

* * *

Veterans Administration reports marked effectiveness in use of chlorothiazide with other drugs in treating high blood pressure. The new drug is said to reduce unpleasant effects from other drugs. Drug combinations with chlorothiazide gave an average blood pressure reduction of 27 per cent, compared with 11 per cent drop in pre-treatment level with older drugs alone. Research is continuing.

* * *

Public Health Service has contracted six research organizations for production of new potential anticancer compounds, antimetabolites and hormonal substances, both of which are known to hinder cancer cell growth. The chemicals will be used on three types of animal tumors and, if successful, will be used clinically in hospitals cooperating with the National Cancer Institute.

* * *

After six months of operating its disability payments program, Social Security Administration reports disability checks total nearly $10-million a month, with average monthly payment $72.24. By next July, number on rolls is expected to reach 200,000 persons. If average payment continues, program then would cost $14,448,000 a month.

* * *

In its first year of operation, Medicare spent $43 million, with $22 million going to civilian physicians and $21 million to civilian hospitals; administrative costs ran about 3 per cent. Some claims were still pending when these figures were announced.

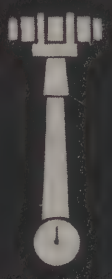
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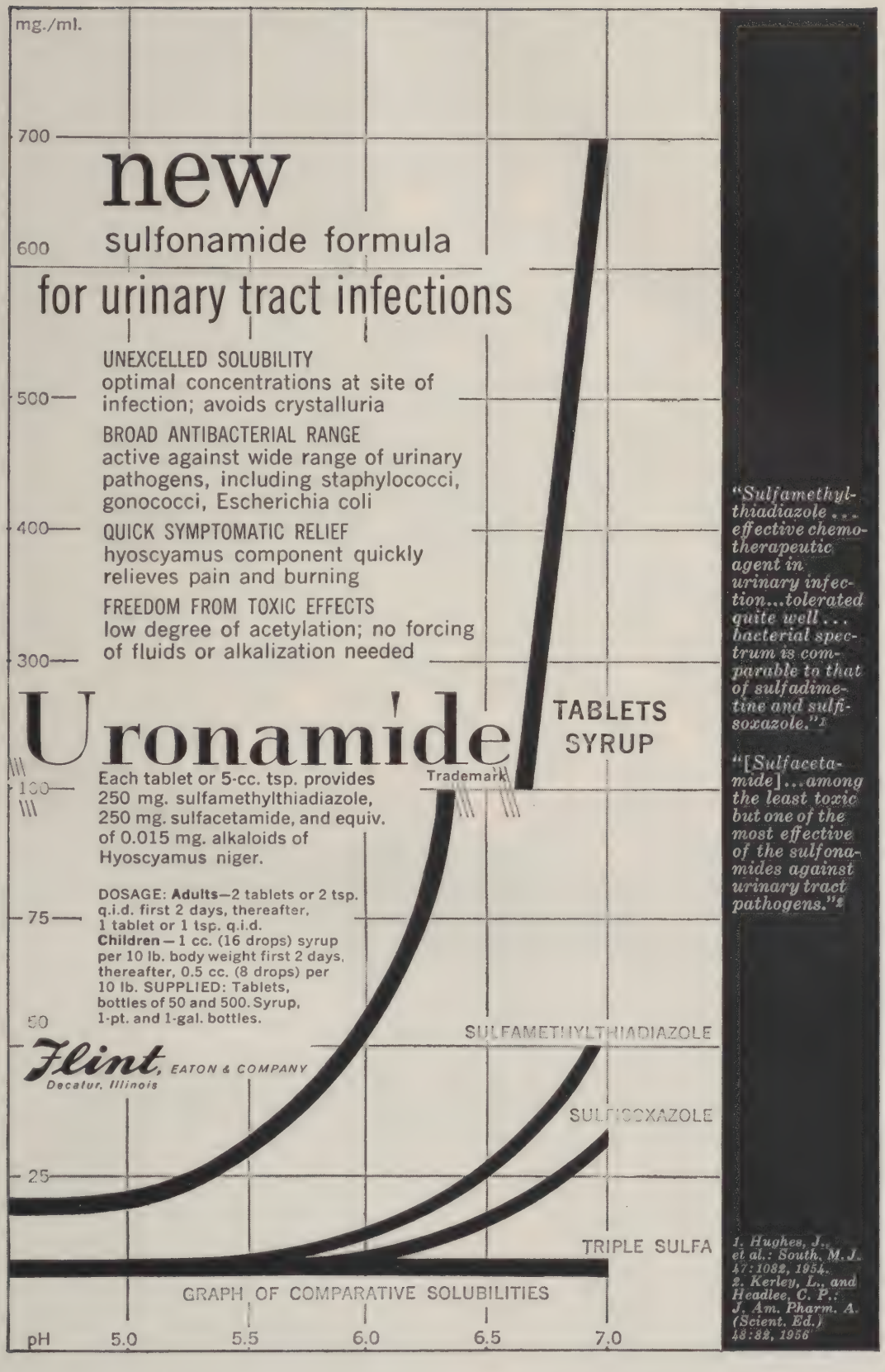
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DOSAGE: **Adults**—2 tablets or 2 tsp. q.i.d. first 2 days, thereafter, 1 tablet or 1 tsp. q.i.d. **Children**—1 cc. (16 drops) syrup per 10 lb. body weight first 2 days, thereafter, 0.5 cc. (8 drops) per 10 lb. SUPPLIED: Tablets, bottles of 50 and 500. Syrup, 1-pt. and 1-gal. bottles.

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"[Sulfacetamide] . . . among the least toxic but one of the most effective of the sulfonamides against urinary tract pathogens."[2]

1. Hughes, J., et al.: South. M. J. 47:1082, 1954.
2. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 48:82, 1956

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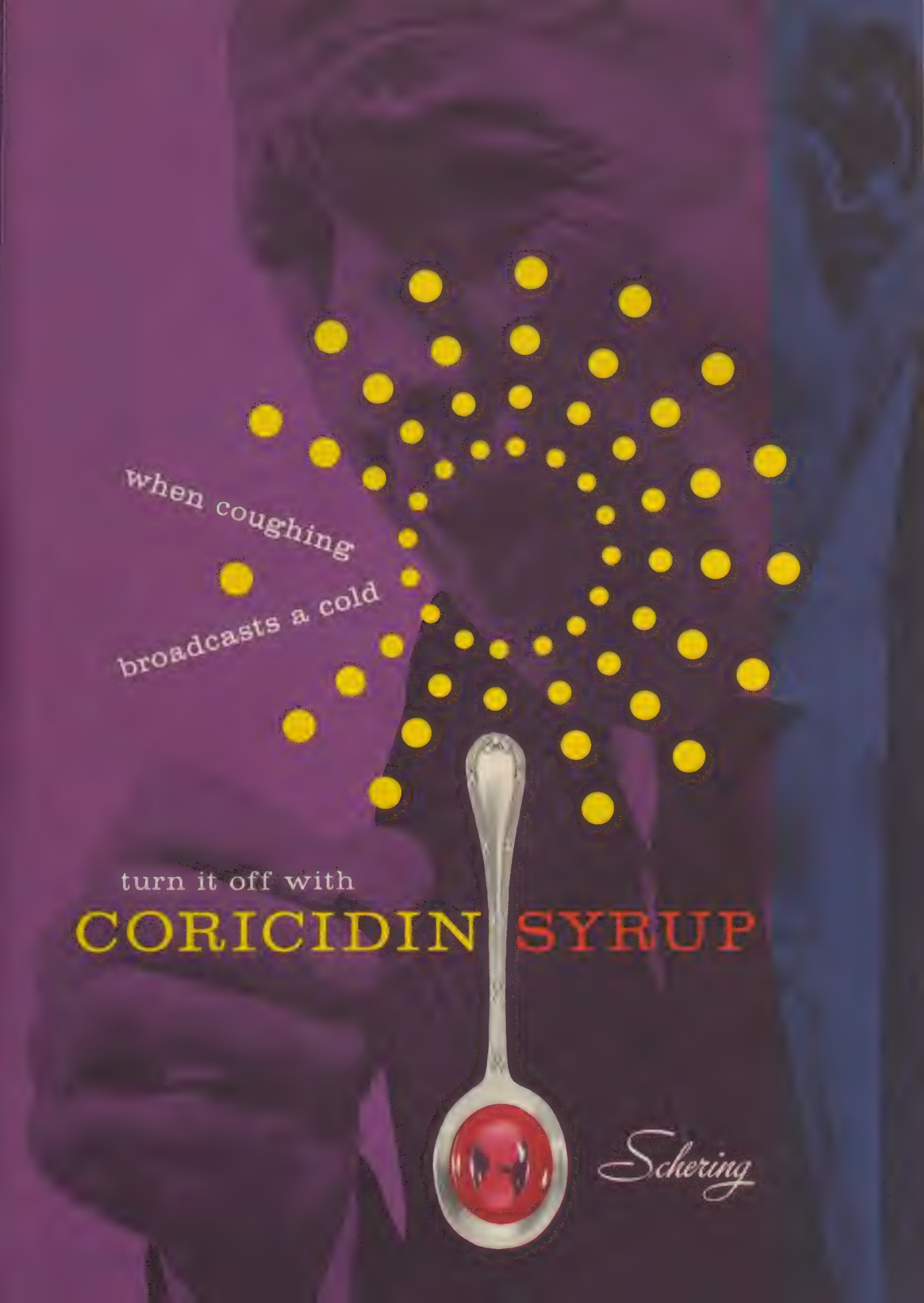
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

GOOD JUDGMENT OF OHIO LEGISLATURE CONFIRMED

At a recent meeting the Council on Industrial Health of the AMA took action advocating discontinuance of the use of fluoroscopes for fitting of shoes. The Council noted that these devices "expose shoe sales personnel and customers, particularly children, and bystanders to a hazard which they do not recognize or appreciate, and cannot be controlled effectively." The resolution stated that fluoroscopes are of no real value in shoe-fitting and that "a high percentage of shoe fitting fluoroscopes are frequently in poor repair and emitting dangerous stray radiation."

It will be recalled that the Ohio General Assembly at its 1957 session enacted a law giving the State Director of Health the authority to regulate the use of fluoroscopes for non-medical purposes. Action of the AMA body confirms the good judgment of the Ohio Legislature.

THIS COULD BE FIRST STEP TO UNIFY RESEARCH

Creation of the American Medical Research Foundation by the AMA could well be a long step in the direction of unifying a great deal of the scattered activities now taking place in the field of medical and health research. Certainly some centralization and standardization of research in medicine and health is badly needed. The House of Delegates of the Ohio State Medical Association expressed that sentiment at the 1957 Annual Meeting. A resolution expressing these views was presented by Ohio delegates to the AMA House of Delegates last June and referred to the AMA Board of Trustees for action. Let's hope that the new research foundation will be used as a vehicle to bring about much-needed improvement in a confused area.

KEEP YOUR POWDER DRY IN WAR AGAINST TB

Although active tuberculosis has declined 30 per cent in five years, there can be no complacency as the general control picture is not entirely reassuring, a report of the U. S. Public Health Service and the National Tuberculosis Association points out, following a nationwide survey.

The check shows that despite intensive efforts for control, almost 40 per cent of the active cases are unknown to health authorities, and these people are not receiving treatment. ("Unknown" cases are estimated on the basis of x-ray survey findings.) In the five years there has been no decrease in number of persons who are or have been ill with the disease, and there are still about 250,000 persons known to have tuberculosis in its active form. The most encouraging phase of the report is that active cases have dropped from 350,000 to 250,000 and inactive cases requiring supervision of health departments from 600,000 to 550,000.

It is obvious that a big job remains to be done.

UNCLE SAM'S HEALTH BUSINESS IS BIG BUSINESS

Running health programs is big business so far as the Federal Government is concerned. If you don't believe it, read the facts as revealed by the latest study on this question by the Washington Office of the American Medical Association —and become convinced that the statement above is true.

Just how much money the Federal government does spend on health programs and just how is it spent are not easy questions to answer. But the AMA office has pieced together all of the bits and pieces of information needed to explain where and how the U. S. is involved in medicine, from cancer research to treating workmen's sniffles, and has come up with the answer that for all health and medical purposes, the U. S. during the current fiscal year which ends next June 30 is spending approximately two and one-half billion dollars. This—despite months of economy talk in the administration and in Congress earlier in the year—is about the same figure as last year.

The survey also unearthed some interesting sidelights that show perhaps more graphically than the dollar marks the extent to which Federal medical activities are spreading among almost all agencies and departments.

At least 23 U. S. cabinet departments and independent agencies are engaged in some medical operations, and there are at least 79 separate health-medical activities worthy of listing and describing. Many of these in turn are responsible for scores and scores of individual operations.

This year the relatively new Department of Health, Education and Welfare tops the list of all departments in health-medical spending with $849,394,800, bounding past Veterans Administration and Defense Department, which up to now have been at the head of the column. VA is spending $849,374,000, within $20,000 of HEW, but Defense Department this year drops back more than $80-million, to $702,000,000, largely because the decreasing size of the armed forces means fewer uniformed men and dependents to care for.

Next comes Atomic Energy Commission, but its medical spending of $40-million—mostly for

research—is far down the column from the Big Three.

International Cooperation Administration has $37-million to help our friends overseas to raise their medical standards. The other 19 departments and agencies have substantially less, the last item being the $12,145 allocated to the physician entrusted with keeping members of Congress as healthy as possible.

For the first time the AMA report compiles information on the programs in which the U. S. participates for payments because of disability. Among those receiving these payments are veterans, disabled beneficiaries under social security, disabled railroad workers, etc.

Because this money is not all Federal and comes from several tax sources—OASI and railroad payroll deductions as well as general U. S. revenue—it is not added to other federal medical costs in the AMA study. For the current fiscal year the total of these "payments for disability" is about $3.2-billion.

PUBLIC WILL COOPERATE IF PROPERLY TOLD

Some time ago a radio station in Pittsburgh presented a program, sponsored by the local medical society, on the importance of autopsies.

Since then it is reported that the autopsy rate in Pittsburgh has risen from 38 per cent to 60 per cent, apparently because of the program.

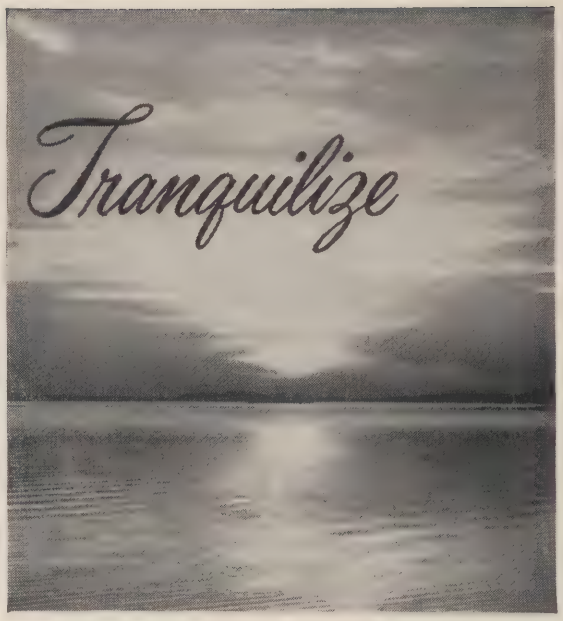
Hunch for medical societies and hospitals in areas in Ohio where there is need for an increasing in the autopsy rate!

AMA DOLLARS SPENT IN EFFECTIVE MANNER

Now that it is time for members to pay 1958 dues in their local, state and national medical societies, one hears, occasionally, this question: "What does the AMA do with its money?"

In our opinion, the AMA does not have to apologize for what it does with its money as the over-all program of the AMA is a good one and the money is being spent wisely and effectively. Nevertheless, for the information of all, here is a breakdown on some of the major expense items in 1956, in round figures, exclusive of costs of publishing the AMA Journal and other magazines:

Public relations, $400,000; Council on Medical Education and Hospitals, $376,000; Bureau of Health Education, $296,000; Washington Office, $227,000; Council on Medical Service, $206,000; Membership Records, $202,000; Bureau of Medical Economic Research, $173,000; Biographical Records, $155,000; American Medical Education Foundation Overhead, $119,000; Law Department, $111,000; Bureau of Exhibits, $109,000; Council on Drugs, $99,000; Council on Industrial Health, $76,000; Council on Rural Health, $68,000; Council on Medical Physics, $61,000; Council on Foods and Nutrition, $56,000.



CARBASED

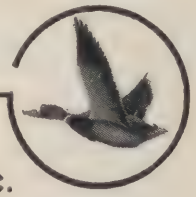
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- Soothes the central nervous system, produces calmness without hypnosis.
- Non-toxic, non-cumulative, non-addicting, no known contraindications.
- Does not impair mental or physical function.
- Orally effective within 30 minutes for sustained action up to 6 hours.
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STOP respiratory congestion orally

relief in minutes..lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

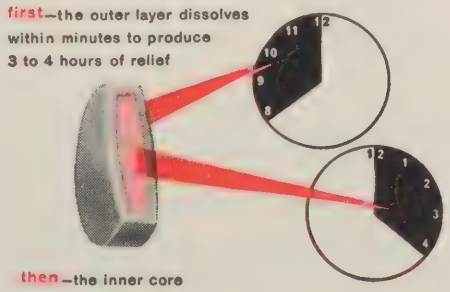
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

Each double-dose "timed-release" TRIAMINIC *Tablet contains:*

Phenylpropanolamine hydrochloride	50 mg.
Pyrilamine maleate	25 mg.
Pheniramine maleate	25 mg.

Dosage: 1 tablet in the morning, afternoon, and in the evening if needed.

Each double-dose "timed-release" tablet keeps nasal passages clear for 6 to 8 hours—provides "around-the-clock" freedom from congestion on just three tablets a day



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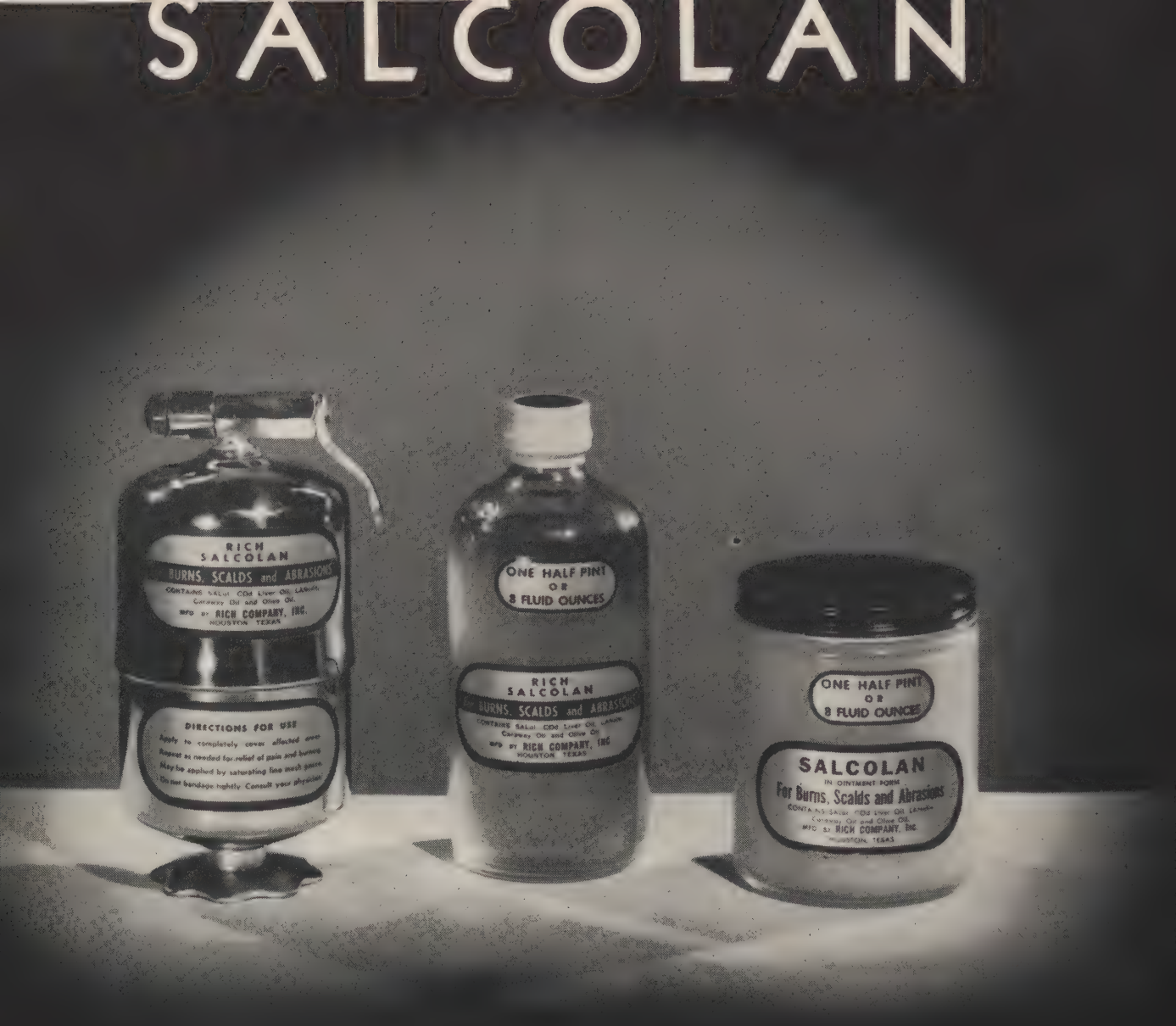
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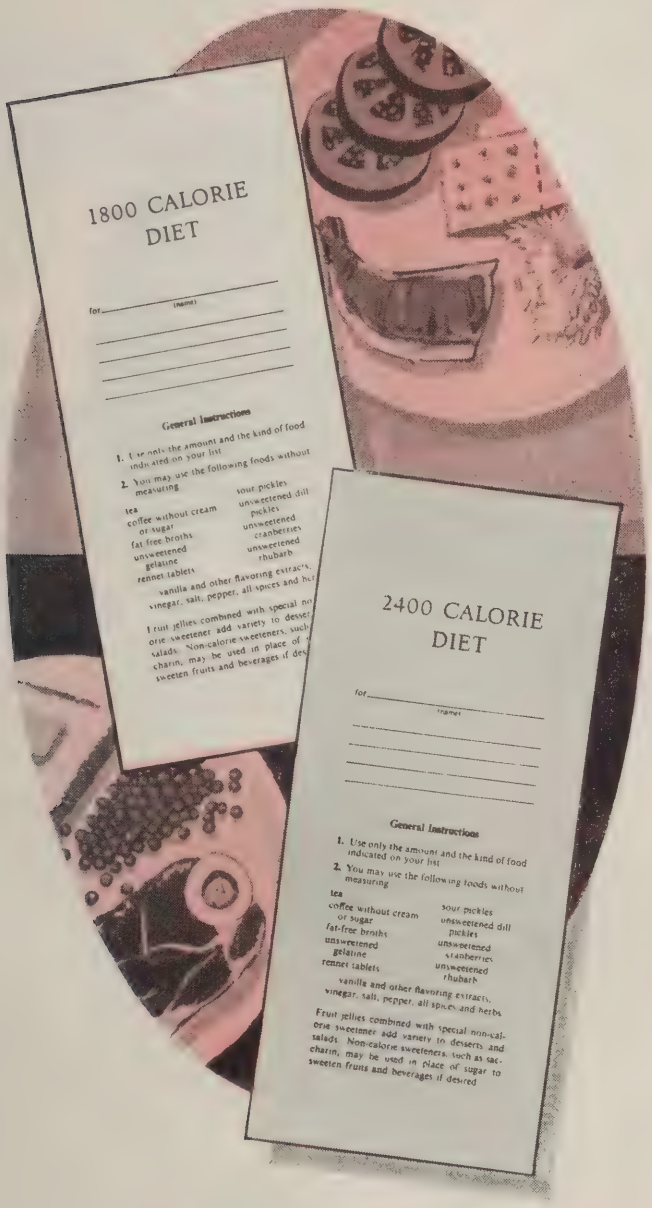
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Vitamin A* (natural) . . . 5000 U.S.P. Units
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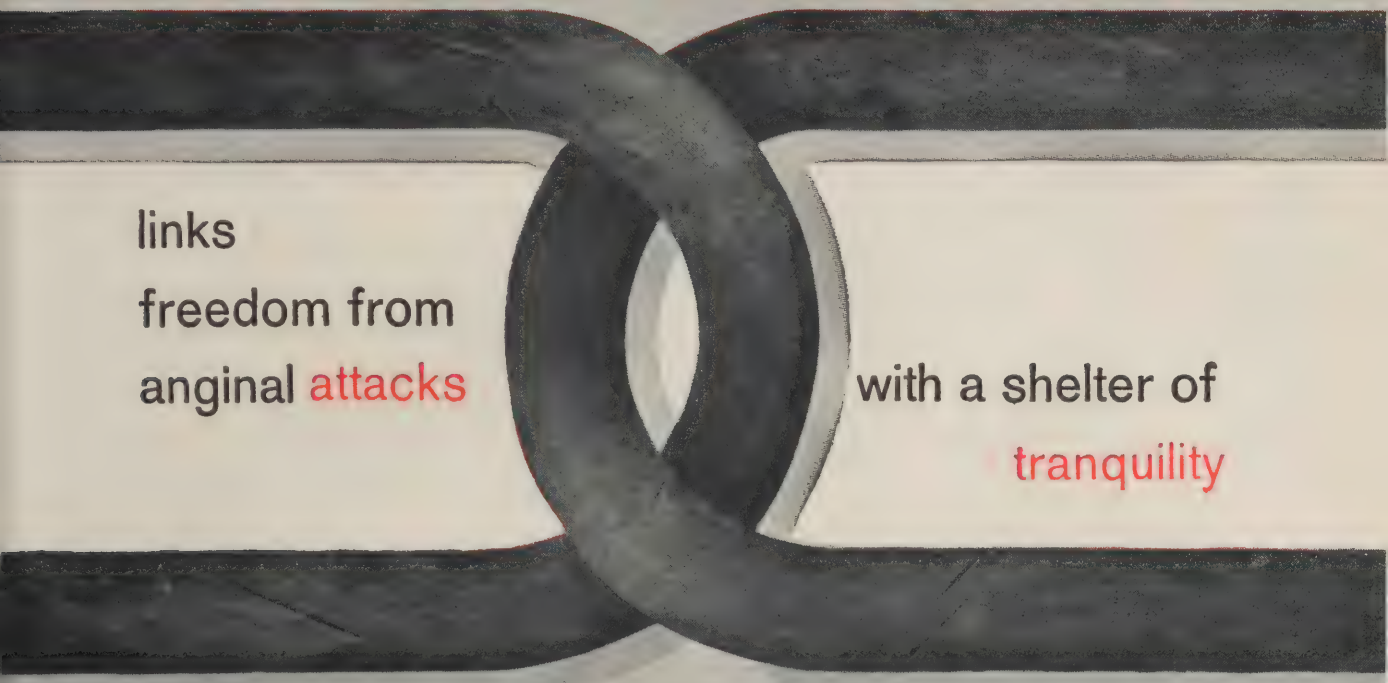
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new for angina

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For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated, this may be increased for more optimal effect by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100. CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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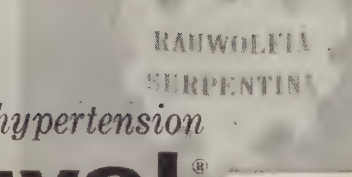
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. . . the preferred drug where anxiety or emotional agitation must be controlled

. . . provides sedation without hypnosis, a sense of relaxed well being and tranquility

. . . effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies



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. . . double assayed to insure optimal therapeutic effect

tested chemically to insure total alkaloid content

tested biologically to insure uniform hypotensive action

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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

"MARCH OF MEDICINE" TV PROGRAM TO BE AIRED JANUARY 23

The work of American physicians in remote regions of the world where native populations are largely dependent upon our doctors and medicine for their health and wellbeing is the television story to be aired coast-to-coast January 23. Entitled "MD International," the hour-long show will be presented at 10 p. m. EST over the full NBC-TV network both in color and black and white. This is part of a joint American Medical Association and Smith, Kline & French Laboratories project to inform the American public of people-to-people activities in the health profession for the promotion of better international understanding.

SCHEDULE RURAL HEALTH CONFERENCE MARCH 6-8

Changing patterns in nutrition, health costs, medical care, dental health and safety will serve as the focal point for discussion at the 13th national Conference on Rural Health to be held March 6-8 at the Hotel Heidelberg, Jackson, Miss. The conference is sponsored by the AMA's Council on Rural Health in cooperation with southern state medical associations and farm, educational and allied organizations.

TWO NEW EXHIBITS ARE AVAILABLE TO COUNTY SOCIETIES

Reducing and accidental poisoning of children are the themes of two new exhibits the American Medical Association is offering to medical societies early in 1958. (1) "You Can Reduce" stresses the importance of using will power in the selection of foods. The exhibit illustrates the basic foods that should be eaten every day, those to "fill up" on and those to "cut down" on. Three dimensional models depict the calorie content of certain basic foods. (2) "Poisoning of Children in the Home" pinpoints eight leading offenders, such as aspirin, kerosene, old medicines and household chemicals. A display of products on a revolving tree-like arrangement also is included in this portable exhibit. Medical society bookings may be arranged through the Bureau of Exhibits.

AMEF STATE CHAIRMEN TO MEET JAN. 25-26

The American Medical Education Foundation's 1958 fund raising drive for the nation's medical schools will be officially launched January 25-26 at a meeting for state chairmen. This seventh annual conference will be held at the Drake Hotel, Chicago.

AMEF reports that Indiana and South Carolina physicians have endorsed a dues increase to help support medical education. Other states which already have adopted a special dues program are Arizona, California, Idaho, Illinois, Nevada, New Jersey and Utah.

AMA AND HOSPITAL ASSOCIATION STUDY MEDICOLEGAL PROBLEMS

A concerted educational program on medical professional liability is being formulated by a joint committee of the American Medical Association and the American Hospital Association. Among other things, the liaison committee plans to study current medicolegal advisory set-ups in a number of states, the liability of charitable and governmental hospitals, and ways of promoting postgraduate education in the professional liability field.

Representatives appointed from AMA include: Dr. Joseph F. Sadusk, Jr., Oakland, California, chairman.

EXHIBIT HONORED AT CLEVELAND MEET

A "certificate of merit" was awarded the American Medical Association for its exhibit on "Health Appraisal of the School Child" at a recent American Public Health Association convention in Cleveland. The exhibit illustrates examples of the various steps in a complete appraisal program from teacher observation, screening procedures, dental and medical examinations to the follow-through. Developed by the Bureau of Exhibits in cooperation with the Bureau of Health Education, the exhibit is of interest not only to physicians but also to educators and other allied health leaders. To be the most effective, however, the exhibit should be manned by local experts in the field. Medical societies may arrange bookings through the Bureau of Exhibits.

LEGAL PROBLEMS SUBJECT AT CONFERENCE IN MAY

Legal problems currently facing individual physicians and organized medicine will be the primary discussion topics at the second meeting of state and county medical society executive secretaries and attorneys May 9-10 at the Drake Hotel, Chicago. Before the final agenda can be set up, the AMA Law Department hopes that medical societies will send in their suggestions on specific legal subjects that would be of the most interest to them. The first such meeting—also sponsored by the Law Department—was held in April, 1956.

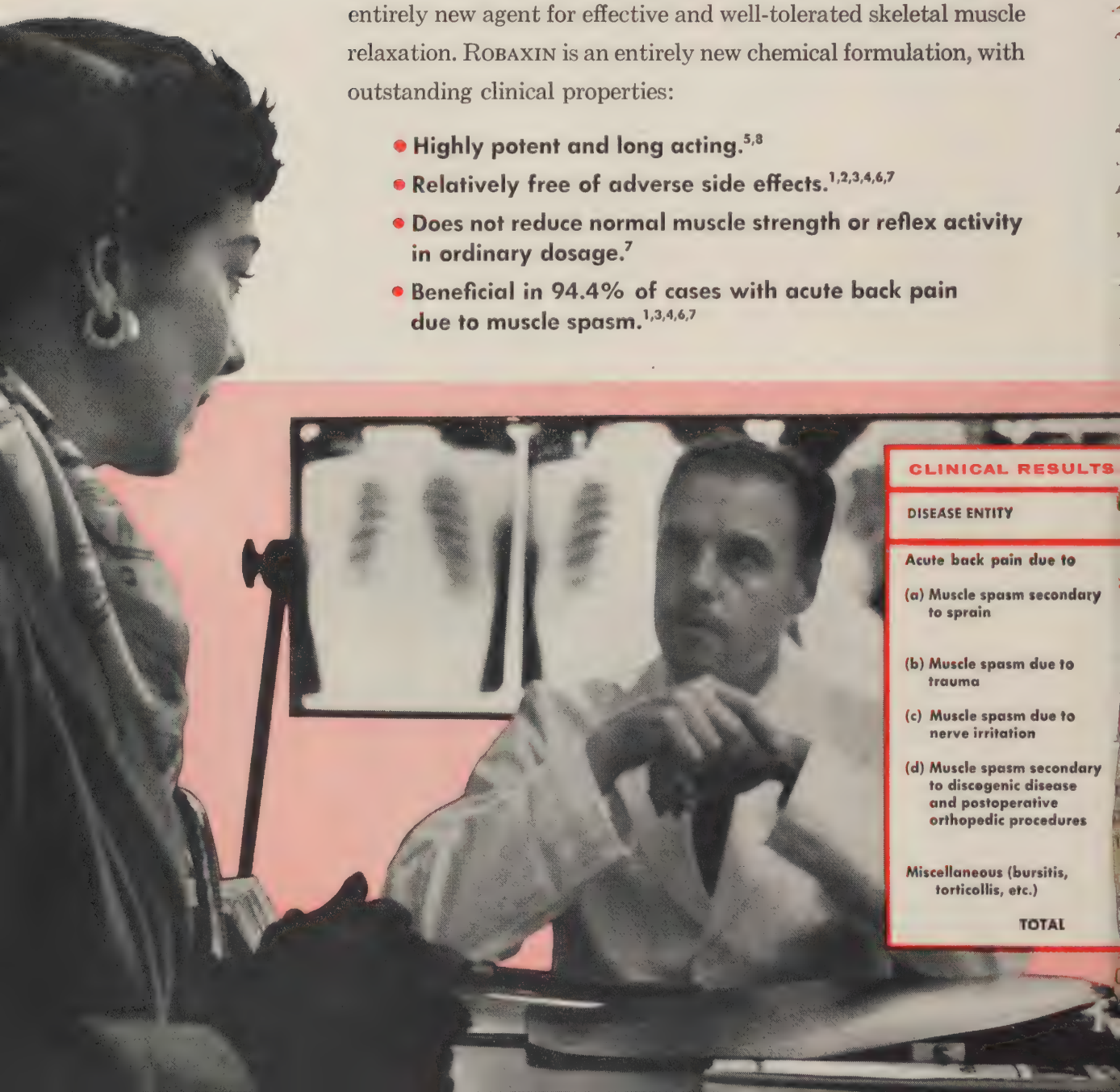
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ROBAXIN – synthesized in the Robins Research Laboratories, and intensively studied for five years – introduces to the physician an entirely new agent for effective and well-tolerated skeletal muscle relaxation. ROBAXIN is an entirely new chemical formulation, with outstanding clinical properties:

- **Highly potent and long acting.**[5,8]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



CLINICAL RESULTS	
DISEASE ENTITY	
Acute back pain due to	
(a) Muscle spasm secondary to sprain	
(b) Muscle spasm due to trauma	
(c) Muscle spasm due to nerve irritation	
(d) Muscle spasm secondary to discogenic disease and postoperative orthopedic procedures	
Miscellaneous (bursitis, torticollis, etc.)	
TOTAL	



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Highly specific action

ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

WITH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

NO. OF CASES	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
18	2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
12	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
5	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
20	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
6	3-60 days	4-8 Gm.	6	0	0	0	None, 6
72			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

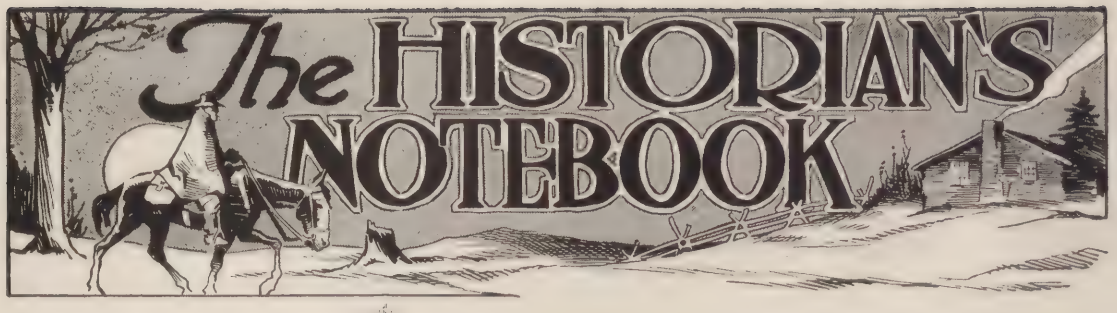
Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

Supply – Robaxin Tablets, 0.5 Gm., in bottles of 50.

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Meetings of the Faculty of Starling Medical College in 1859

JONATHAN FORMAN, M. D.

FROM time to time *The Journal* has presented under this department minutes of the meetings of the faculty of Starling Medical College in 1858 and 1859. In the August 1957 issue, minutes were presented in which the Museum of the College was discussed. The following proceedings report discussions and actions at subsequent meetings of the faculty.—EDITOR.

MINUTES

Saturday evening, the 23d January, 1859

"The Faculty met pursuant to a regular call. Minutes of the preceding meeting were read and adopted. The Committee on the Museum lumber, repair &cc made a partial report and requested for time for completion of the duties assigned them. *Granted.*

"Dr. Hamilton presented the petition of Dr. Ulamer of the Ohio State prison, requesting the honorary degree of Dr. of Medicine for Dr. Sapp of Marion. *Laid on the table* for further action. Dr. Hamilton was requested to obtain other recommendations.

The Dean enquired when the commencement of the present session shall be held. The Faculty decided on Tuesday, the 1st day of March next as the proper day.

"The Dean said there was some uncertainty as to whether Mr. C. N. Olds will be able to fulfill his promise to deliver the address at the commencement and that other names had better be suggested, that some other gentleman's name be found, who will undertake to write and deliver the address in case Mr. Olds does not fulfill his promise.

"Dr. Hamilton said that probably the Revd. Anson P. Smythe would be a good man for the occasion. Dr. Dawson mentioned G. M. Parsons. Dr. Loving suggested the name of the Revd. J. Dilloms. The Dean was requested to confer with one or more of these gentlemen to ascertain whether any one of them will deliver the address should Mr. Olds fail; he was at the same time requested to prevail on Mr. Olds to deliver the address if his engagements will permit.

"Lovejoy's and Ewing's plans and proposals for casing and shelving for the museum presented by the committee on repairs: Lovejoy presented two plans—one plain, and the other called by him *Gothic.* He agreed to furnish the plain casings for $2.50 per lineal foot complete except the painting and the shelves. The Gothic he agreed to furnish complete except shelves and painting at $2.75 per lineal foot.

"Ewing presented a plan entirely plain, which he agreed to furnish complete except for painting for $2.37½ per foot (lineal).

"The Faculty discussed both plans of Lovejoy and Ewing and did not accept nor reject either positively, and referred the matter back to the committee who were instructed to contract for the casings on the best terms to be obtained, and reserve the right to select the glass necessary for the same.

"For the present it was thought best to case the west side of the Museum Room only.

"There was some discussion as to what would be the propriety of endeavoring to get a bill passed by the present legislature by which it would become lawful for the medical students to visit the County Infirmary as often as it may be necessary and advisable for the purpose of receiving clinical instruction. Dr. Carter suggested that, as the matter was one of importance, a committee had better be appointed to consider it and advise a plan to get the bill passed by the Legislature. *Carried.*

"The Committee appointed on motion by Dr. Carter consists of Doctors Hamilton and Dawson.

"There being no further business before the

Faculty, on motion, the meeting adjourned. Next meeting to be held in the Museum Room on the evening of Saturday, Feb. 5, at 7 and one-half o'clock Pm.

"S. LOVING, *Secy.*"

* * *

Saturday evening, the 5th February, 1859

"The Faculty met pursuant to a regular call.

"Present: The Dean, Hamilton, Wormley, Carter and Loving. Dr. Smith also came in sometime after the Faculty had been in session. Minutes of previous meeting accepted.

"The report of the Committee on the Museum Repairs was called for. Dr. Loving from said Committee said that the committee could not make a report at this time as the duties assigned to it were not yet completed and requested further time. *Granted.*

"Certificates of several medical gentlemen concerning the character of Dr. L. Reynolds of Beverly, Ohio, and recommending Dr. R. to the Faculty as a proper person on whom to bestow the honorary title of Doctor in Medicine were presented by the Dean.

"These certificates were written by Drs. I. Huestis, C. Buchanan, and J. Little, also, Dr. J. W. White. These gentlemen gave Dr. Reynolds a very high character as a professional man and as a citizen, and after hearing them read, the Faculty decided that Dr. Reynolds is a proper person on whom to bestow the Honorary Degree of Doctor of Medicine, and agreed that his name be presented to the Trustees with the recommendation that they grant said Degree.

"Dr. Hamilton presented the name of Dr. J. W. Hodge of Tuscarawas County and asked that his name be presented to the Trustees for the Honorary Degree. Dr. Hodge, in Dr. Hamilton's opinion, being worthy of the honor although comparatively a young man.

"The application was discussed pro and con, and upon expression of disapproval by some of the members, Dr. Hamilton asked and obtained leave to withdraw his application.

"The application, on motion by Dr. Smith, was reconsidered, and after some discussion, the name of Dr. J. W. Hodge was directed to be presented to the Trustees with a recommendation that the Honorary Degree be conferred upon him.

"It was then decided to present the name of Dr. Stephen Rogers of Tacna in Peru to the Trustees for the same degree. Application by Dr. Loving.

"The name of Dr. J. L. Wortman of Muskingum County presented again by Dr. Hamilton.

"Dr. Hamilton thought Dr. Wortman worthy of the Honorary Degree, but the Faculty decided otherwise, and the application, on leave, was withdrawn.

"There was some discussion as to the propriety of a Summer course of Lectures. And finally, on motion by Dr. Carter, Drs. Hamilton and Loving were appointed a committee to ascertain how many students of the present class will remain in the event of a Summer Course being decided upon. The Dean then called attention to the catalogue of Messrs. Bossange & Fils of Paris, sent by mail, through their agents in New York. Messrs. B. & Fils are dealers in materials for museums such as anatomical, physiological and pathological specimens, casts, etc. Catologue was examined.

"The Faculty then adjourned to meet at the Museum Room on Saturday evening February 12th, 1859.

"S. LOVING, *Secy.*"

* * *

Saturday evening, the 12th February, 1859

"The Faculty met pursuant to adjournment. Present all the members.

"Minutes of the preceding meeting were read and adopted.

"The name of Dr. Ecmann recommended by Dr. Nelson as worthy of the Honorary Degree, again presented by the Dean who wished to know what action shall be taken with regard to the application. Dr. Smith moved that the application be accepted,and that Dr. Ecmann's name be presented to the Trustees for the Honorary Degree. *Carried.*

"The Dean presented a letter from Dr. _____ of Jelloway, Delaware County, Ohio, asking permission to present himself for examination for the Degree of Doctor of Medicine, he having attended a full course of lectures at the University of Michigan at Ann Arbor and practiced regularly four years. He agrees to pay the graduation fee if he can obtain permission to be examined. The Dean said he had neither encouraged nor rejected the application, but had written to him and requested him to visit Columbus that the Faculty may decide as to the merits of his application. He wished the Faculty to decide whether his course has been proper in the matter.

"The Faculty decided that the Dean had acted properly, and further, that if the Dr. comes and attends the lectures from the present time until the end of the course or close of the sessions and pays the fees for a full course of lectures including the matriculation fee, he shall be admitted to examination.

"On motion of Dr. Hamilton, Dr. E. L. Wortman of Muskingum County, on complying with the same terms is to be admitted to examination for the Degree of Doctor of Medicine.

"The report of the Committee on the Summer Course of Lectures called for. The committee could only present a partial report. It presented the names of eight students, four of whom would certainly attend and four who would probably attend such a course.

"Dr. Smith moved that a Summer Course be given, to begin on the first day of April next, and continue until the first day of July, and that

three lectures be given daily for five days in the week. *Carried.*

"Dr. Dawson moved that a circular be issued stating the times, etc. of said course. *Carried.*

"It was decided, as above stated, that three lectures be given daily for five days in each week during the proposed Summer Course, and that the Professor of Theory lecture on the Diseases of the Nervous System and Physical Diagnosis; that the Professor of Obstetrics lecture on the Diseases of children; that the Professor of Surgery lecture on the Diseases of the Eye and Ear, on Anatomy as connected with these organs, and Minor Surgery; that the Professor of Chemistry lecture on Animal Chemistry and Toxicology; that the Professor of Anatomy lecture on Physiology and Microscopic Anatomy; that the Professor of Materia Medica and Therapeutics lecture on Hygiene and the Principles of Therapeutics.

"Dr. Carter, from committee of one, reported in favor of allowing Dr. W. Muley compensation of the same amount as heretofore; namely, three hundred dollars per annum for the present year, to be paid as heretofore, part in cash ($100) and part in good notes ($200).

"Dr. Smith at this time, by permission, absented himself giving Dr. Carter power to vote for him, (making Dr. Carter his proxy).

"Dr. Carter's report was then discussed pro and con, and the question was called for by different members of the Faculty, but the Dean refused to put the matter to vote, as in his opinion it required the votes of all the members of the Faculty (and the presence of all the members).

"There being no further business for transaction, the Faculty adjourned to meet at the Museum Room on Saturday evening, February 19th, 1859.

"S. LOVING, *Secy.*"

Post Surgeon J. G. Andrews' Diary Is Now Available

Journal of Dr. Joseph Gardner Andrews, (post surgeon at Fort Defiance in 1795) edited by Richard C. Knopf for the Ohio Historical Society. ($3.00. *Ohio State Museum, Columbus 10, Ohio.* Publication date, October 1, 1957.) Of the scores of military and frontier journals, this is, by far, the finest. Not only is it a day-to-day account of Andrews' own activities, but contains interesting sidelights to frontier garrison life and an acute insight into his own medical practice.

Andrews might well have performed the first autopsy west of the Alleghanies. He also experimented with various methods of relieving the rigors of malaria. A Harvard graduate, a former Dorchester, Massachusetts, schoolmaster and, finally, an army surgeon, Andrews exemplifies the finest attributes of the eighteenth century gentleman, scholar, and scientist.

The Story Behind the Word

Some Interesting Origins of Medical Terms

Wintergreen—A hardy, flowering woodland plant, found in almost all parts of the northern hemisphere and so named because its leaves remain green all winter. The leaves yield a fragrant, pleasant-tasting oil, which is used extensively as a flavoring for candy, medicine, chewing gum, tooth powders and similar preparations. The oil is also used as a lotion.

Wen—This word is derived from the Anglo-Saxon word "wenn," which in turn may have come from the Gothic word "winnan" meaning pain, or "to suffer." Originally the Anglo-Saxon word "wenn" meant any soft, fleshy or wart-like tumor. In the nineteenth century the term came to be restricted to mean a sebaceous cyst and especially one located on the scalp.

Waldeyer's Ring—The lymphatic tissue of the pharynx, palatine tonsil, or lingual tonsil form a ring of lymphoid tissue around the entrance to the pharynx. This was pointed out by Heinrich Wilhelm Gottfried Waldeyer, a German anatomist in 1884, and has since been known as Waldeyer's Ring.

Yawn—A term descriptive of the act. It is derived from the Anglo-Saxon word "ganian" literally meaning "to gape" or open wide. It is interesting to note that the Greek term for yawn is "chasma," meaning a separation or chasm, while the Latin term for yawning is "hiat" coming from the Latin "hio" meaning "to open."

Zygoma—This bone was so named by Galen because of its yoke-like shape. The term is derived from the Greek word "zygon," a yoke.

Zoology—This branch of biology deals with the study of animals. Aristotle who lived about 350 B. C. is considered the father of zoology, however it was Linnaeus who in 1735 established it as an orderly science. The word *zoology* is derived from the Greek word "zoon" or animal, plus "logos," a discourse.

Zoster—A Greek word meaning a girdle or belt. Medically the term is used synonymously with zona and shingles.

—HARRY WAIN, M. D., Mansfield, Ohio.

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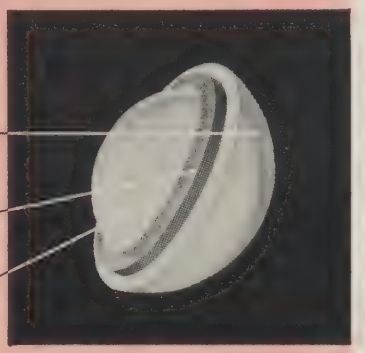
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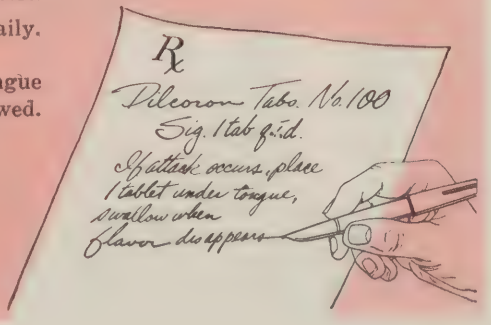


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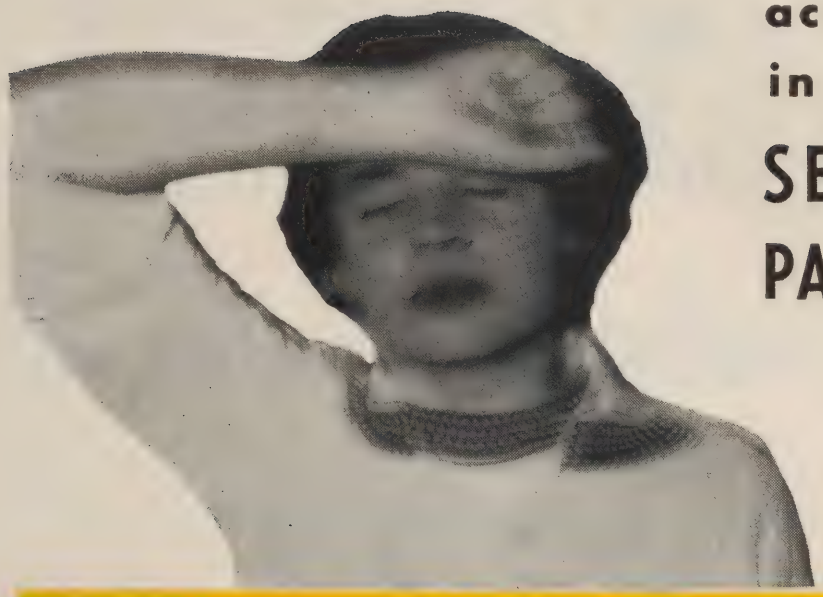


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*Joseph, Morris: Effective Analgesia Without Sedation or Narcosis, Clinical Medicine, August 1957.

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†Ayd, F. J., Jr.: The Treatment of Ambulatory and Hospitalized Psychiatric Patients with Trilafon, presented at Ann. Meet., Am. Psychiat. Assoc., Chicago, Ill., May 13-17, 1957.

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Vol. 54 January, 1958 No. 1

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A Comparative Evaluation of a Sustained Release Liquid Sulfonamide, Penicillin, and Oral Tetracycline in Pediatric Practice

MARVIN McCLELLAN, M.D.

THE increasing incidence of antibiotic-resistant bacteria, superimposed bacterial and fungal infections, and sensitization reactions associated with the use of antibiotics has elicited a great deal of concern among physicians. For example, excluding editorials and mentions in papers dealing with antibiotic-resistant bacteria, 23 articles cautioning against the indiscriminate use of antibiotics have appeared in the literature since 1952.[1] Along with these cautions, a hypothesis has arisen that the use of less potent antimicrobial agents should be considered before using antibiotics in treating common infections.[2, 3, 4] According to Yow,[2] the use of less potent drugs, such as the sulfonamides, in treating common infections will delay the development of antibiotic-resistant organisms and will make the antibiotics more effective when used to treat serious infections.

The following report describes a comparative evaluation of a new, sustained release liquid sulfonamide*, penicillin, and a combination of penicillin and an oral pediatric suspension of tetracycline** in treating pediatric patients with moderately severe bacterial infections.

MATERIAL AND METHOD

PATIENTS

A total of 472 children with moderately severe bacterial infections were treated during the evaluation. The children ranged in age from 4 months to 17 years; 238 were girls and 234 were boys. Two hundred and thirty-three children were treated with the sustained release liquid sulfonamide preparation; 207 were treated with penicillin, and 25 were treated with penicillin and oral tetracycline. In addition to the foregoing groups of patients, 6 children received the sulfonamide preparation and penicillin simultaneously and 1 child received the sustained release sulfonamide prophylactically.

Patients were seen at home and in the office. Their symptoms were those usually associated with systemic bacterial infections and consisted of pyrexia, general malaise, pertussis, frequency of—or burning—upon urination, vomiting, abdominal pain, diarrhea, or mucus exudation of the nose, throat, or ears. Physical examination of the children commonly revealed enlarged, inflamed tonsils with follicular exudation, enlarged tender glands, inflamed tympani with or without exudation, pulmonary rales, furuncles, and bullous skin lesions. Microscopic examination of the urine of patients with infections of the

*"Sul-Spansion®," Trademark of Smith, Kline & French Laboratories, Philadelphia, Pa.
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The Author

● **Dr. McClellan, Cincinnati, is a member of the staffs of Children's Hospital of Cincinnati, and Good Samaritan Hospital; instructor, Department of Pediatrics, The University of Cincinnati College of Medicine.**

urinary tract revealed the presence of pus and blood cells.

Diagnoses of the patients were as follows: Upper respiratory infections, 131; otitis media, 121; lower respiratory infections, 166; glandular infections, 15; urinary tract infections, 8; skin infections, 21; and miscellaneous infections, 10.

After the children had been examined and a diagnosis was made, one of the medications was administered. Except for the group of patients who received penicillin and tetracycline, penicillin or the sustained release sulfonamide preparation was administered to every other patient. Parents were instructed about the administration of medications and were asked to record the child's temperature and his symptomatic response to therapy.

The response of each child was noted daily by personal communication with the parents or by subsequent visits with the patient. All patients were examined to determine the clinical remission of the infection. Follow-up examinations were conducted on practically all of the children when they were seen at a later date for routine physical examination or for immunization treatment. The evaluation lasted for one year.

DRUGS

The liquid, sustained release preparation contained sulfaethylthiadiazole, a newly available sulfonamide, present in the form of thousands of microscopic spheres suspended in a fruit-flavored aqueous vehicle. Upon ingestion, a percentage of the tiny spheres disintegrate immediately and release a sufficient amount of sulfaethylthiadiazole to produce a blood concentration within the range of 8 to 15 mg. per 100 ml.[5] The rest distintegrate gradually over the next 8 to 10 hours and provide a continuous flow of the sulfonamide into the blood. This continuous absorption of small amounts of drugs into the blood compensates for renal excretion and keeps the blood concentration at a relatively constant level.

By taking the preparation every 12 hours, the initial blood concentration can be maintained for prolonged periods of time.[5] Besides producing excellent therapeutic blood concentrations, sulfaethylthiadiazole is highly soluble in the usual *p*H ranges of urine,[6] and is excreted almost entirely from the body in 48 hours.[7] The antibacterial effect of the drug covers a wide range of gram-negative and gram-positive organisms including many of the antibiotic-resistant bacteria.[8]

Aqueous salts of penicillin-G were used during the evaluation. The pharmacology and bacteriological effect of these compounds have been described by Goodman and Gilman.[9] An aqueous salt of penicillin-G (administred intramuscularly) and an oral pediatric suspension of tetracycline were given simultaneously to a small group of patients.

DOSAGE

The maintenance dose of the sustained release sulfonamide preparation was based on one-half teaspoonful (0.32 Gm., or 5 gr.) for every 15 pounds of body weight every 12 hours. Children over 75 pounds were given the adult dose of 1 tablespoonful every 12 hours. Prophylactic doses of the preparation were one-half the maintenance dose and were also given every 12 hours. All initial (priming) doses of the drug were twice the amount of the maintenance doses.

The initial dose of penicillin was administered intramuscularly; subsequent doses were taken orally. When patients showed a minimal response to therapy, a second and often a third dose of penicillin was administered intramuscularly even though the patient was taking the drug orally. Intramuscular doses of penicillin varied with the size of the child and ranged between 300,000 and

TABLE 1.—RESULTS OF THERAPY WITH THREE ANTIBACTERIAL AGENTS

Diagnosis	Sustained Release Sulfonamide			Penicillin			Penicillin/Tetracycline		
	No. of Patients Treated	Cured	Failed	No. of Patients Treated	Cured	Failed	No. of Patients Treated	Cured	Failed
Otitis Media									
Unilateral	32	28	4	21	20	1	1	0	1
Bilateral	31	28	3	27	22	5	5	5	0
Follicular Tonsillitis									
Acute	27	26	1	50	48	2	2	2	0
Chronic	6	6	0	3	3	0	0	0	0
Pharyngitis									
Acute	21	20	1	18	15	3	0	0	0
Chronic	2	2	0	1	1	0	0	0	0
Bronchitis									
Acute	42	38	4	24	22	2	5	5	0
Chronic	2	2	0	0	0	0	0	0	0
Tracheobronchitis	43	39	4	18	17	1	8	8	0
Tracheitis	5	3	2	0	0	0	0	0	0
Bronchopneumonia	4	4	0	8	7	1	0	0	0
Pneumonia	0	0	0	0	0	0	1	1	0
Bronchiolitis	2	2	0	0	0	0	0	0	0
Laryngotracheobronchitis	0	0	0	4	3	1	0	0	0
Lymphadenitis	0	0	0	10	9	1	3	3	0
Urinary Tract Infections	5	5	0	3	3	0	0	0	0
Skin Infections	3	2	1	18	16	2	0	0	0
Miscellaneous	8	7	1	2	2	0	0	0	0
Totals	233	212	21	207	188	19	25	24	1
Percent		90.9	9.1		90.8	9.2		96.0	4.0

500,000 units. Oral doses of penicillin varied between 400,000 and 900,000 units per day.

In the group of children treated with penicillin and tetracycline, penicillin was administered only once, at the beginning of treatment. This dose varied between 300,000 and 500,000 units and was given intramuscularly. Tetracycline was started immediately after administering penicillin. The doses varied between 500 and 750 mg. per day.

RESULTS

No elaborate rating scale was used to judge the results of therapy. If the patient improved steadily and became clinically well on the medication he was given originally, the patient was considered "cured." If the patient did not respond to the initial medication and had to be changed to another drug, the patient was considered a "failure" on the original medication.

Results are shown in table 1 and are given according to diagnoses. Of the 233 patients who received the liquid, sustained release form of sulfaethylthiadiazole (every 12 hours) 212 (90.9 per cent) were cured and 21 (9.1 per cent) were not; 188 (90.8 per cent) of the patients who were treated with penicillin in miltidose regimens were cured and 19 (9.2 per cent) were considered failures; 24 (96.0 per cent) of those given penicillin and tetracycline were cured while 1 (4.0 per cent) patient was not benefited from these drugs. A statistical analysis (chi-square test) of the number of patients who were cured by each of the medications does not show a significant difference (chi-square = .4579, $p = .75$), indicating that each of the medications was equally effective in bringing about the clinical remission of the infection.

The number of treatment days required for the patient to become clinically well following therapy with each of the medications are shown in table 2. Considering only those patients who had a favorable response to therapy, the average number of treatment days required to effect the clinical remission of the infection was 6.9 days for the sustained release liquid form of sulfaethylthiadiazole, 5.8 days for penicillin and 6.1 days for penicillin and tetracycline.

A statistical analysis (Analysis of Variance Test) indicates that there is a significant difference between the average number of treatment days for the sulfonamide treated group and the average number of treatment days for the two groups treated with other medications ($f = 35.42$, $p = > .01$). There is no significant difference between the average number of treatment days for the groups treated with antibiotics. Although a statistically significant difference exists between the number of treatment days required to produce a clinical remission of the infection with the sulfonamide preparation and the other medications, it is doubtful where the actual difference in time (maximum of 1.1 days) has any medical significance.

Only one of the six patients who received the liquid sustained release sulfaethylthiadiazole and penicillin simultaneously failed to benefit from these drugs. He was subsequently treated with chlortetracycline and had an uneventful recovery. A patient who had had several recurrences of follicular tonsillitis over a ten month period was given the sulfonamide preparation prophylactically for 2 weeks. She has remained free from infection for eight months.

Only one child developed an allergic skin reaction while taking the sustained release liquid form of sulfaethylthiadiazole. Four other children developed skin reactions while receiving this drug but the rashes were subsequently diagnosed as varicella or roseola infantum. One patient each reported mild diarrhea and vomiting. The drug was not discontinued in either of these patients and the untoward reactions disappeared without supportive medication. Two children developed rashes while receiving penicillin and one child became febrile and developed chills. The drug was discontinued in all three patients and the untoward reactions disappeared without the use of additional medication. No untoward reactions were reported for the small group of children who received penicillin and tetracycline.

Seven patients became re-infected within two to three weeks after the initial infections had been cleared. Three of the re-infections occurred in patients who initially had received penicillin and four re-infections took place in patients who had been taking the liquid sustained release sulfonamide medication. All seven patients were given the same drug as they had received for

TABLE 2.—DURATION AND RESULTS OF THERAPY WITH THREE ANTIBACTERIAL AGENTS

No. of Days of Therapy required for complete recovery	Sustained Release Sulfonamide		Penicillin		Penicillin & Tetracycline	
	Cleared	Failed	Cleared	Failed	Cleared	Failed
3	1	1	3	0	0	0
4	6	4	28	1	1	0
5	30	3	54	6	10	0
6	28	6	46	5	4	0
7	45	4	22	4	3	0
8	96	3	31	1	6	1
9 or more	6	0	4	2	0	0
TOTALS	212	21	188	19	24	1
Total Number of Treatment Days	1482		1105		147	
Average Number of Treatment Days	6.9		5.8		6.1	

their initial infection and became clinically well in a short period of time. None of the 25 patients who had receved penicillin and tetracycline became re-infected.

COMMENT

The lack of statistical difference in the results of therapy obtained with each of the medications indicates that therapy with the sustained release liquid form of sulfaethylthiadiazole is equivalent to that of penicillin alone and penicillin given simultaneously with tetracycline. These data support the hypothesis of Yow,[2] that sulfonamide therapy suppresses most of the systemic bacterial infections seen in routine office practice and, therefore, offers an alternate form of therapy in treating these infections.

Based on the number of treatment days required to produce the clinical remission of the infections, penicillin and penicillin and tetracycline are somewhat superior to the sulfonamide preparation. In actuality, the slight difference (maximum of 1.1 days) observed in the number of treatment days required for each of the medications had little medical significance.

The number of untoward reactions reported during the evaluation were minimal regardless of the medication used. The number of patients who became re-infected after having been cured once was approximately equivalent for penicillin and the sustained release liquid form of sulfaethylthiadiazole which further substantiates the slight difference in effect produced by either of the drugs.

SUMMARY

1. Four hundred and seventy-two children with moderately severe bacterial infections were treated with one of three antibacterial medications. Two hundred and thirty-three children received a liquid, sustained release preparation containing sulfaethylthiadiazole; 207 children received penicillin; and 25 children received penicillin (intramuscularly) and an oral pediatric suspension of tetracycline.

2. Two hundred and twelve (90.9 per cent) of the patients treated with the sustained release liquid form of sulfaethylthiadiazole were cured, 188 (90.8 per cent) treated with penicillin were cured, and 24 (96.0 per cent) treated with penicillin and tetracycline were cured. The average number of treatment days required by each of the medications to bring about a clinical remission of the infection was 6.9 days for the sustained release sulfaethylthiadiazole, 5.8 days for penicillin and 6.1 days for penicillin and tetracycline.

3. A statistical analysis (chi-square tests) of the number of patients cured with each of the medications failed to show any significant difference (chi-square = .4579, p = .75). A significant difference existed between the number of treatment days required for clinical remission of the infection for patients receiving the sulfonamide preparation and those receiving the other medications. The maximum difference between the number of treatment days for all of the medications was only 1.1 days and seemed to have little medical significance.

4. The side effects and number of re-infections observed with the sustained release form of sulfaethylthiadiazole and penicillin were approximately equal, indicating little or no difference in effect produced by either of the drugs.

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Encopresis in Children Due To Psychogenic Factors

The term *encopresis* was first used by Weissenberg in 1926 to denote psychogenic fecal soiling. Incontinence of feces due to organic disease is usually referred to simply as fecal soiling; the term encopresis is restricted to fecal soiling of emotional origin. In children who have no grossly evident neurologic disease, fecal soiling is so commonly emotional in origin that the term encopresis tends to be applied to virtually all fecal soiling in children.

That fecal soiling may be emotional in origin was observed as early as 1882 by Fowler. (Am. J. Obst., 15:985, 1882.) Fowler reported a case in which undue educational pressure by the parents on a 7 year old boy had turned him into an automaton who could spout endless amounts of factual data, which gratified his ambitious parents. However, as Fowler pointed out, "Under such conditions it is not to be wondered that something gave way and, fortunately for the brain, it was the anal sphincter."

Since Fowler's original observations various authors have pointed out the psychogenic factors in encopresis. Burns (Brit. Med. J., 2:767, 1941) describes encopresis as a "psychogenic disorder . . . in protest against an inimical and threatening environment; an unconscious reaction both of aggression and fear." Detailed psychiatric studies of children with encopresis are rare: Warson (Am. J. Orthopsychiat, 24:402, 1954) reported a case intensively studied over a period of time, in which it was felt the encopresis was a reaction to various insecurities and inadequacies in the mother-child relationship. Other authors have described a broader spectrum of emotional factors causing encopresis.— A. H. Chapman, M. D., et al., Kansas City: *Missouri Med.*, 54:751, August, 1957.

A Child Health Survey

Part I: The School and Family as Sources of Health Information

R. A. LYON, M.D., LOUISE W. RAUH, M.D., C. A. WEIHL, M.D.,
F. W. KELLOGG, M.D., and KATHRYN D. LAVRICH, M.D.

THIS project was undertaken to determine the specific health problems of children in an area near, but outside the limits of a large city. Although cities contain many doctors, hospitals and laboratories, it is questionable whether they are available to families, especially those of lower economic levels, who live 20 to 30 miles away. The survey also permitted the testing of several different techniques for evaluation of health of children.

THE ADDYSTON CHILD HEALTH SURVEY

Addyston was suggested by the Hamilton County Health Department as a suitable area for a child health survey because it was a small, compact community with an active health committee greatly interested in the welfare of the children. This committee, composed of the district nurse, the school principal, teachers, parents and other citizens, had previously requested a rheumatic fever survey, help in the fields of nutrition and mental health, and additional medical and dental care since there was neither a doctor nor a dentist residing in the corporate area.

The survey was made by members of the Child Health Association and the Pediatric Department of the Medical College, in close cooperation with the Hamilton County Health Department and the Health Committee of Addyston. Other organizations lending help and counsel were the Cincinnati Pediatric Society, the Babies' Milk Fund Association, the Preventive Medicine Department of the Medical College, the Heart Association of Greater Cincinnati and its subsidiary The Children's Heart Association, the School Health Committee of the Academy of Medicine, the Antituberculosis League, the Public Health Federation, and the Children's Dental Care Foundation.

PLAN OF INVESTIGATION

The program began with (1) physical examinations of school children as a rapid method of obtaining an insight into their health problems. (2) In succeeding weeks certain children with serious or with questionable defects were selected for a leisurely, more thorough examination with the mother present. (3) Further information regarding the children's health, activities and behavior was sought from teachers and parents by personal conferences or by written questionnaires, and finally (4) a community survey was conducted to determine economic, social or environmental conditions which might influence physical or mental health of the children.

The Authors

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THE EXAMINATION OF SCHOOL CHILDREN

Plan. Considerable time was spent in planning for the school examination, first with the Health Committee of the school, and then with the medical and nursing staffs who participated. The groups decided that a large scale examination of the entire student body in one day would create more interest and would be less disturbing to the school routines than repeated grade by grade examination at weekly intervals. It seemed unlikely that the quality of the examination would suffer if a sufficient number of physicians and volunteers could be recruited for the occasion. Whenever a child was encountered who had a problem requiring more thorough investigation, he was re-examined at a subsequent time.

Preliminary Testing. Prior to the day of examination the school nurse had carried out the following procedures:

(1) Vision tests with the Snellen wall card.

(2) Hearing tests with group audiometer

procedures in all grades except kindergarten and the first grade.

(3) Measurements of height and weight of all of the children.

(4) Tuberculin patch tests.

(5) Collection of reports from parents and teachers regarding any particular diseases or abnormalities of behavior which they had noticed in the children.

The Examination. A total number of 322 children of the school population of 356 were examined throughout the day by a staff of six physicians, aided by the two staff nurses, four volunteer nurses and six mothers who guided the children and recorded the results.

The examination lasted about four and a half hours so that approximately 72 children were seen each hour by the group of six, or a rate of 12 pupils per hour per physician, which constituted an average of about five minutes spent on each child. This does not include the time spent by the nurse in preliminary testing.

Positive findings were recorded at once on the child's school health record where all of the results of previous tests and measurements were reviewed. From these records the accompanying table of abnormalities was prepared. (Table 1.)

Questionnaires sent home to the parents had asked for comments on the health of their children, but less than half of the families returned their reports. Many of the replies mentioned past illness or recurring symptoms and when they were checked against the pupils' health records they were found to represent recent temporary illness or suspicions of disease rather than fundamental disorders. However, these reports of symptoms tended to make the professional staff more alert in searching for organic disease. Excluding the records of past infectious diseases, the contributions made by the parents were summarized as follows:

"DEFECTS" ADDED BY PARENTS AND NOT KNOWN PREVIOUSLY BY NURSES OR DOCTORS

Frequent colds	17	Heart Murmurs	4
Eye Disorders	10	Nervousness	3
Ear Disorders	6	Questionable Tuberculosis	3
Frequent Headaches	5	Anemia	2
Frequent Nose Bleeds	5	Leg Pains	2

The teachers were also asked to record the outstanding abnormalities of health and behavior of the pupils in their classes. Many of these problems had been discussed in personal conferences between nurses and the principal and teachers in previous months. From these sources came the most valuable information concerning the children's behavior. A group of 19 children were considered to have abnormal patterns of conduct requiring further study. There were also some reports of a few chronic infections and symptoms not previously known by the nurse.

"DEFECTS" ADDED BY TEACHERS AND NOT KNOWN PREVIOUSLY BY NURSES OR DOCTORS

Behavior disorders or abnormalities	19
Frequent colds, tonsillitis	3
Frequent headaches	2

SUBSEQUENT EXAMINATIONS

Not satisfied with the diagnosis made in some instances during the first screening procedure, the medical staff arranged for subsequent examinations and a few laboratory tests of a selected group of children. Included in this group were the underweight pupils and those who had such

TABLE 1.—DEFECTS OCCURRING IN CHILDREN OF VARIOUS GRADES

	Number of Children by Grade								
	Total	Kdg.	1	2	3	4	5	6	7	8
Children Examined	322	30	58	37	40	30	31	39	36	21
Defects										
1. Dental	179	14	41	24	27	20	7	17	17	12
2. Eye	46	5	1	1	7	7	3	7	7	6
3. Heart murmurs	36	2	4	3	2	1	2	8	10	1
4. Underweight } 25	15	3			2	2	2	3	2	1
Overweight }	10		1	1	1	1		1	1	1
5. Skin infections, marks	15	6	2	2	1	2			1	1
6. Positive tuberculin test	13		3	2	1	1	2		2	2
7. Ear	8		1		1			2		1
8. Feet—low arches	6		1				3	2		
9. Enlarged glands	4		3							1
10. Inguinal hernia	2				2					
11. Umbilical hernia	2		1		1					
12. Adrenogenital syndrome	2		1		1					
13. Large liver	2						1		1	
14. Meningocele—spastic	1				1					
15. Thyroglossal duct cyst	1				1					
16. Undescended testis	1				1					
17. Speech defect	1								1	
18. Known rheumatic fever	1								1	
19. Mongoloid features	1		1							
20. Asthma	1	1								
21. Funnel chest	1		1							
22. Lordosis	1		1							
23. Protruding abdomen	1		1							
24. Torticollis	1	1								
25. Large tonsils	1	1								
26. Nocturia—"weak kidneys"	1					1				

vague complaints or physical findings as "weak kidneys," large liver, frequent headaches. The staff also wanted to review the treatment received by some of the children who had chronic disorders.

To carry out this part of the program, one physician conducted a clinic at the school one-half day a week for six weeks where she conferred with the parents, reviewed the records and examined the patients. Facilities for urinalysis and hemoglobin determinations were provided.

No additional diseases or abnormalities were discovered at these subsequent examinations. Many of the children with minor symptoms were found to be in a good state of health and enjoying active normal lives. Medical care had been available to every child, although the patients who depended upon clinic care at the Cincinnati hospitals were forced to spend the greater part of a day in making the trip and in waiting for medical care. There was a glaring lack of facilities for clinic dental care in the Addyston area and in Cincinnati.

THE COMMUNITY SURVEY*

Another step taken by the staff was a community survey to evaluate environmental and social factors which might influence the health of the children.

This project included a house to house canvas to interview parents regarding family health and availability of medical care, and it provided a chance to observe environmental conditions such as sanitation, housing and recreational facilities. During the summer months of 1956 a total number of 269 families, composed of 1039 individuals, were interviewed. The results may be summarized as follows:

The population of Addyston is fairly stable and more than 80 per cent of the families have lived in the area for five years or more. They were lower in economic level than many suburban communities, since 14 per cent received their support from county welfare agencies. Although 15 families (6 per cent) contained more than 10 members, the average family size was 4.9.

Health Problems. No particular childhood diseases or abnormalities were discovered which had not been known by the nurses and doctors. There was a tendency for the families to postpone smallpox vaccination for children until they reached school age, but almost all of the children had been immunized against diphtheria and tetanus in infancy. The need for dental care was widespread and most of the families expressed their desire to use dental facilities if they were available.

Medical Care. Addyston was fortunate in having infant welfare clinics, tuberculosis clinics and a nursing service. More than 400 individuals of Addyston had attended one of the clinics at some time or other, and chest films for tuberculosis had been taken on an equal number.

Almost all of the families had had medical care from private physicians at some time or other, especially for acute illness. Twenty-five per cent of the population had also used the clinics for preventive procedures or for special tests. About 80 per cent of the population had some form of hospital insurance.

Housing. Although there was a wide range in quality of homes, Addyston seemed to have a high proportion of substandard dwellings. Less than half of the homes had inside toilets and a central sewage disposal system was just being installed. Approximately 30 per cent of families owned their own homes, while the remainder, who rented their dwellings, paid an average of $27.00 per month. Upkeep on the rented homes was at a low level and their condition was conspicuously poor compared to that of houses owned by the inhabitants. Average home size was 4.4 rooms.

Milk supplies were clean and running water was available in all but 20 homes (7 per cent). The great majority of homes had electric refrigerators, screens for windows and doors, and almost all had television sets.

Social Conditions. The majority of the children attended Sunday School or church services regularly and about two-thirds of the mothers belonged to the P. T. A., which seemed to be a very creditable showing. Other organized groups for social and sporting activities were limited to the efforts of the school and an occasional group such as the Boy Scout Troop. The number of cafes in the area was larger than might be expected and they furnished a large part of the social life for the men.

The incidence of illegitimate births, broken homes and delinquency seemed high, although it was impossible to determine these factors accurately and to find suitable figures with which they could be compared.

There seemed to be a notable indifference of families to community recreational projects. Previous attempts to develop such programs have failed because of lack of support from the families of the area.

DISCUSSION

For this survey of child health conditions the school was the best single source of information. Here the school nurse had collected such a large amount of data from her tests for physical health and her conferences with teachers and parents that the additional case finding procedure of physical examination yielded rather meager results. The value of the selection of health problems of pupils by teachers has been em-

*Parts of this survey were carried out by Mr. George Chiligiris and Mr. Robert Price, Junior Medical Students who were recipients of summer Fellowships provided by the Poliomyelitis Foundation and Department of Preventive Medicine, The University of Cincinnati College of Medicine.

phasized in the studies reported by Nyswander [1] in 1942 and by many others since. Yankauer and Lawrence [2] have recently observed the paucity of newly discovered defects uncovered by repeated routine annual examinations of children in primary grades of school. Although 14 per cent of their series of children developed abnormalities after the first examination, most of these defects could have been found by other simpler means.

The best information regarding the child's behavior and social adjustment came from the principal, the teachers, and the nurse. Parents furnished very little additional data in response to questionnaires or at first interviews. Possibly they hadn't recognized any deviations of behavior in their children or possibly they didn't care to discuss such matters. On better acquaintance with an interviewer, many parents divulged more information.

The house to house canvas revealed valuable additional information to the surveying team. It provided the data regarding the health of the children and adolescents who were not in school as well as the background of social and hygienic conditions. Again the school nurse and faculty knew most of the conditions reported by the surveying staff. Had there been a physician practicing actively in the community, he too would likely have been familiar with the health problems and their underlying causes. While the surveying team of physicians did not uncover any significant diseases or unfavorable health conditions not known previously, it stimulated interest in the health program and gave an impetus to the carrying out of the recognized procedures for case finding.

The next step was a review of the facilities for treatment of the defects of physical and mental health. Seven conditions which occurred with more than casual frequency were defects of the eyes, ears and teeth which ranked high in frequency as they do in most communities of this sort. Added to these were the problems of positive tuberculin tests, heart murmurs, nutritional variations and behavior. The way in which the community was handling these problems will be described in the next report.

SUMMARY

1. A survey of families living on the fringe of a metropolitan area indicated that the children were receiving medical care comparable to that available within the city.

2. Health examinations of children conducted at the school revealed physical defects which had generally been recognized by parents, teachers, or nurse and had been cared for previously.

3. From conferences with teachers and parents the surveying team could best select the children with abnormal behavior.

4. A house to house survey provided a background of social and economic conditions which might influence the health of the children.

5. Seven of the most common health conditions amenable to prevention or treatment included defective vision and hearing, dental caries, malnutrition, heart murmurs, positive tuberculin reactions and abnormal behavior.

6. A subsequent report will deal with the methods by which the community met these health problems.

Acknowledgements: Many teachers and parents of Addyston and members of the Hamilton County Health Department helped with this survey. Particular mention must be made of the school principal, Mr. Meredith Hitchens, the school nurse, Mrs. Mary Jane Kromer, and the local physician who helped with the examinations, Dr. Frank J. Scharold.

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Steroid Withdrawal

When patients have been treated with adrenal glucocorticoids equivalent to or more than 60 mg. hydrocortisone daily for prolonged periods, usually two months or more, and withdrawal is abrupt, an alarming syndrome may develop within 24 to 48 hours. It is characterized by weakness, nausea, vomiting, abdominal pain and generalized muscular cramps.

The mechanism is due to pituitary suppression of endogenous ACTH, and although ominously masquerading as acute adrenal cortical insufficiency, the syndrome is nonfatal, because the adrenals, if present, continue to produce the powerful sodium retainer, aldosterone. Symptoms usually subside in two to five days. This syndrome can be prevented or minimized by gradual discontinuance of steroid therapy.

Equally as important, a recrudescence of disease may, and usually does, occur, sometimes to fulminating degree. This is highly influenced by the general condition of the patient.

In order to decrease this unpleasantness, all patients on prolonged use of steroids should carry purse cards indicating diagnosis and treatment so that those who ministrate to them following trauma may not err by failing to administer additional life-saving hormone. Following prolonged steroid therapy, it is probably wise to cover stressful events during the next six months with parenteral hydrocortisone sodium hemisuccinate.—Hulon Lott, M. D., Baton Rouge: *J. Louisiana M. Soc.*, 109:415, November, 1957.

Male Breast Carcinoma

The generally poorer prognosis of carcinoma of the male breast may be due to several reasons. The short distance the tumor cells must traverse with early invasion of the surrounding tissues and its associated complications coupled with a greater delay in seeking advice may be the most significant.—F. A. Selecman, M. D., et al.: *Texas State J. Med.*, 53:694, September, 1957.



On The Next Pages,

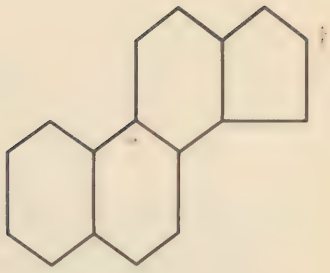
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- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Lower incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are below compared to the reported incidence of those from prednisone and prednisolone.

Peptic Ulcer

The most recent study available on the incidence of peptic ulceration in patients with rheumatoid arthritis on long-term prednisone therapy reported 12 ulcers in 49 cases (24 per cent).[1] Lowest incidence of 6.5 per cent has been recorded in a group of patients on this drug for six to nine months.[2] Four of six ulcers, in another series of 39 patients on prednisone,[3] appeared in less than three months of therapy.

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The incidence of compressed fractures of vertebrae—and to a lesser extent in other bones—is high in patients on prolonged therapy with all previous corticosteroids.[4] One group of 49 patients[1] on long-term prednisone treatment experienced nine vertebral fractures (18 per cent); another series of 39 developed eight fractures (20 per cent),[3] four to 15 months after the beginning of steroid administration.

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[5]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[4] and toxic syndromes producing even convulsions and death.[6]

Since the onset of these complications is not directly related to duration of steroid administration,[7] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension-Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[8] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[5,9]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[10,11] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[5] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[12] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[8] and in inflammatory and allergic skin diseases (33-50 per cent).[13,14]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in a lower incidence of the major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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Lederle

The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

Dust Diseases and Pulmonary Tuberculosis

P. C. PRATT, M. D.

IT is a widespread assumption that the inhalation of particulate material must be harmful to the lungs. Thus, it is always difficult to convince the medical student in pathology that most materials can be inhaled for many years without demonstrable damage to lungs. When finally convinced of this, the student usually suggests that at least the accumulated dust must predispose to infection. He is again surprised to learn that of all the various infectious agents, from viruses through bacteria to fungi, the only disease known to be affected by inhaled material is tuberculosis.

MINERALOGY OF DUST DISEASES

Furthermore, the only substance clearly established as capable of affecting tuberculosis is so-called free silica, or silicon dioxide, usually crystallized as quartz, although other forms of free silica crystals (cristobalite, tridymite) and amorphous free silica are also active.

When silica is combined with base metals (sodium, calicum, potassium, magnesium, etc.) as glass, or as one of the many crystalline silicate minerals (garnet, tourmaline, mica, etc.), its presence in lung exerts no ill effect upon the tissue or the course of tuberculosis. An exception is the mineral asbestos which produces a diffuse fibrotic disease, asbestosis. This has not been clearly shown to influence the incidence or prognosis of tuberculosis although of course there have been cases of asbestosis in which patients developed fatal tuberculosis. Discussion of the possible carcinogenic activity of asbestos is beyond the scope of this summary. Nonsiliceous materials (carbon, iron, etc.) similarly are probably harmless to normal tissue except perhaps in extremely high concentrations or when mixed with free silica. Again an outstanding exception is beryllium which causes a granulomatous pulmonary disease in occasional individuals. Some of these patients have developed fulminating tuberculosis, but there is no evidence of a high incidence of this.

CHARACTERIZATION OF TUBERCULOSILICOSIS

The disease resulting when both silicosis and tuberculosis occur together is called tuberculosilicosis and is a characteristic pulmonary disease differing from either silicosis or tuberculosis alone. Thus, while tuberculosis in the days before effective drug therapy was considered to be a chronic relapsing disease with a strong likelihood of ultimate stabilization and arrest, tuberculosilicosis was known as a prolonged, gradual and consistently progressive disease. It had relatively little symptomatology until late in the course when excavation would develop, the rate of progression would increase and death from tuberculosis or pulmonary insufficiency would surely follow.

Silicosis alone, on the other hand, is characterized by the presence of generalized fibrous nodules throughout the lungs, but has not been demonstrated to cause measurable interference with pulmonary function. Pathologically, the reason for this is quite clear since the fibrous nodules are generally sharply defined and the intervening pulmonary tissue remains essentially normal with small alveolar spaces and thin alveolar septa.

DIAGNOSTIC PRINCIPLES

The requirements for the diagnosis of tuberculosilicosis include a history of adequate exposure to free silica dust, the presence of generalized nodulation in both lungs by x-ray, and the presence of infiltrations or conglomerate massive shadows, often bilaterally symmetrical and extending outwards from the hilum. The tuberculin test must be positive, although often only weakly so. Demonstration of tubercle bacilli in sputum is highly desirable but is often exceedingly difficult, especially in the noncavitary stages, and therefore is not absolutely required for the presumptive diagnosis.

EVALUATION OF EXPOSURE

General exposure to free silica dust occurs in many industries but even in such well known types as potteries and foundries, certain workers may not be significantly exposed. It is important to ascertain not only the type of industry, but the duration of the actual job or jobs performed by any individual suspected of having silicosis. Details of the various jobs performed and types of dust control or personal protection employed must be evaluated. While certain situations of extreme exposure have been known to produce silicosis in as little as two years, it is a good rule-of-thumb that at least 10 to 15 years of exposure are required.

It should also be noted that even in industries not characteristically involving silica exposure,

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This article was prepared in corrobation with the Publications Committee of the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

there may be individual jobs entailing such exposure. For example, there is a job in the railroad industry which involves the preparation of sand for use in providing traction. The worker holding this job may be heavily exposed to free silica dust.

TREATMENT AND PROGNOSIS

In the days before effective drugs, the treatment of tuberculosilicosis was generally unsuccessful. Bed rest and collapse therapy, even thoracoplasty, seemed not to influence the progressive course of the disease. In the early years of drug therapy, when short courses were given, improvement in roentgenographic shadows did occur, but this usually was temporary and relapses occurred promptly if therapy was stopped or if the bacteria became resistant.

Currently the outlook for therapy seems much more promising. With prolonged combined drug therapy, many cases have apparently stabilized. Some such cases are continued on therapy for life, while a few have been taken off and have maintained their stabilization. Some patients have been successfully treated by surgical resection of massive conglomerate lesions with cavities.

Treatment of Penicillin Reactions Should Be Immediate

When a penicillin reaction has occurred, the most important feature of the treatment is that it be immediate! The physician must keep the proper syringes and drugs available for use at all times. The following suggestions should be followed if the patient complains of any of the symptoms that have been described.

1. A tourniquet should be applied above the site of the injection, if possible.

2. Epinephrine (1:1,000 acqueous solution), given subcutaneously in doses of 0.5 to 1.0 cc., is the drug of choice, and it should be repeated if the patient does not respond within a few minutes. In a desperate situation, these drugs should be given intravenously.

3. Antihistamines should be given intravenously. Benadryl® or Pyribenzamine® (25 to 50 mg.) or Chlor-trimeton® (10 to 20 mg.) may be given. (Use only material labeled for intravenous use.)

4. Aminophyllin (0.25 to 0.5 Gm. in 10 cc. intravenously) will be especially helpful if marked wheezing and dyspnea are present.

5. Hydrocortisone in 100 mg. doses should be given intravenously as soon as possible. As an emergency procedure, the usual contraindications or side effects need not be considered, for this may be a life-saving procedure.

6. If cyanosis is present, oxygen should be used.

7. If shock is prolonged, plasma or blood should be given. Norepinephrine can also be used to maintain blood pressure.—Joel D. Teigland, M. D., Des Moines: *J. Iowa M. Soc.*, 47:514, August, 1957.

KEEPING UP WITH MEDICINE

• BY PATCH TEST, allergy to boric acid, aluminum acetate, menthol, petrolatum and phenol has been found to exist in less than 2 per cent of a certain group of patients.

* * *

• FORTY YEARS AGO, one in every 10 babies born alive in this country was unable to survive the first year of life. Today the ratio has dropped to one in 40.

* * *

• THERE remains no direct proof that estrogens are carcinogenic when used therapeutically and the circumstantial evidence has been seriously challenged.

* * *

• SALAD MAKERS and others employed in handling the edible umbellifers—carrots, parsnips, celery (including celery salt)—may have a dermatitis of the hands due to contact with these vegetables but housewives seldom have adequate contact, and ingestion of the vegetables will not produce a flare-up.

* * *

• THE INFUSION of sodium bicarbonate induces both kaluresis and alkalinization of the urine.

* * *

• THE MAJORITY of deaths from hemolytic disease of the newborn could be prevented if (1) adequate prenatal testing were done to predict the possibility of the disease; (2) clinical evidence in the infant were watched for and acted on promptly; and (3) exchange transfusion were carried out under experienced supervision.

* * *

• IT HAS BEEN demonstrated adequately that when corticosteroid or corticotropin are properly used either together or alone, satisfactory results are obtained as a rule in the treatment of pemphigus vulgaris.

* * *

• ONCE IT IS established that the symptoms are menopausal, most patients can be greatly relieved by reassurance, rational explanation of the even and simple psychotherapy.

* * *

• A CASE was recently reported in which it took the combination of acetic acid in the food (pickles or sauerkraut) combined with cold to produce cold allergy. How easily this cause could have been missed and how easy and satisfying it might have been to ferret out the patient's stresses and sex drives and pronounce them as the cause. There is much yet to be learned!

* * *

• ACUTE HEMIPLEGIA associated with infarction in the distribution of the major arterial channels is frequently accompanied by seizures and usually leaves permanent sequelae. Cerebrospinal fluid is usually normal.

* * *

• EPINEPHINE may produce symptoms of tetany in asthmatics.—J. F.

Convulsive Seizures Following Administration Of Chlorpromazine (Thorazine®)

MARTIN J. GUNTER, M. D.

FOLLOWING four years' experience of using chlorpromazine in psychiatric outpatient practice, I would like to describe two instances of grand mal convulsions ascribed to its use. One occurred in a patient following a period of administration of gradually increasing doses up to a relatively high level. The other in an individual who had had only occasional, and small doses, and in whom a convulsion occurred after taking only one small dose of the drug.

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CASE REPORTS

Case No. 1: The patient is 26 year old white male. His father died in a mental institution. In June, 1953, he was discharged from the Army following a period of hospitalization for a psychosis, characterized by auditory hallucinations. He was diagnosed: Schizophrenic reaction, residual type, with hebephrenic and paranoid features. He is a religious fanatic. He revealed considerable anxiety and had many somatic complaints largely on a psychophysiological or even delusional level. There was no remarkable physical, neurological nor routine laboratory abnormality. Chest x-ray was normal.

In November 1954, the patient received elixir of phenobarbital, 4 cc. four times a day with little benefit. It was stopped in December, 1954. On January 21, 1955, he was started on Thorazine,® 10 mg. three times daily. On February 4, this was increased to 20 mg. three times daily. In March, 1955, this was changed to 50 mg. every morning. This was continued for almost a year. In January, 1956 he complained of increased nervousness. An increase to 100 mg. in the morning did not control his symptoms. Therefore, on January 30, 1956, his dose was increased to 100 mg. twice a day; a total of 200 mg. per day.

After one week on this regime the patient experienced a grand mal convulsion. It occurred in the early morning hours, after arising from sleep and on his way to the bathroom. He noted a sudden "blurring" sensation, and immediately fell to the floor unconscious. He bit his lip. There was no incontinence. Unconsciousness apparently lasted a few minutes whereupon patient returned to bed and slept. The attack was followed by a severe headache the next day.

He had had his last dose at bedtime the previous day. He had never had any kind of spells or convulsions in the past. He does not drink. There is no history of a head injury. No epilepsy in family history. He has occasional headaches, not of migraine type. He had never had an electroencephalogram. Up until December, 1956, there have been no additional spells.

Case No. 2: A 35 year old male, in September, 1954, was given a supply of Thorazine for symptomatic use in controlling intermittent spells of anxiety. His intake never exceeded 20 mg. a day, and would average 10 mg. daily, three or four days a week. The first week in November, 1954, he took a 10 mg. tablet in the afternoon. Several hours later he took a 20 minute nap. Upon arising he went to the bathroom. While standing up, without any warning, he lost consciousness, and fell to the floor. The patient recalled still feeling jerking movements as his consciousness returned approximately one minute later. There were no after effects other than pain in one knee due to the uncomfortable position during the seizure.

This patient had no history of any previous attacks nor is there a family history of such. In the past he had suffered from typical, but very infrequent, migraine headaches. For this reason he had had an electroencephalogram in 1951 which was interpreted as within normal limits. There is no history of alcoholism. A neurological examination and x-rays of the skull were normal. There has been no additional spell for over two years now.

DISCUSSION

Chlorpromazine has been used rather extensively in epileptics. Some have reported a decreased frequency of seizures. However, Robb,[1] as well as Lomas[2] and Bonafede,[3] have reported increased number of seizures due to this drug. Montassut,[4] as well as Lomas[2] also described seizures following the use of this drug in non-epileptics.

SUMMARY

Two cases of convulsion due to use of chlorpromazine are described. Both occurred in outpatients who had no history of epilepsy.

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Treatment of Urinary Stress Incontinence

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THE urinary incontinence of women which occurs on coughing, laughing, lifting, or other stress can be cured in the great majority of cases not complicated by neurological or developmental defects. These patients need no longer suffer the embarrassment and discomfort it produces. Four different types of operations specifically designed to restore normal function to the urinary organs have been successfully used in relieving such incontinence. Although each makes a different approach to the problem, the ultimate results are substantially the same. The two techniques which we prefer will be described after a brief review of the anatomy and pathology involved in stress incontinence.

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THE URINARY BLADDER

The mucosal lining of the bladder is covered by three layers of involuntary muscle with an intermingling of voluntary fibers. The fibers of the inner and outer coats are longitudinal, and those of the thick middle coat are circular or spiral. There is an outer covering of fascia, which is particularly strong on the side adjoining and attached to the vaginal fascia. The posterior wall of the bladder, known as the trigone, is believed to represent the absorbed caudal ends of the Wolffian ducts. It is a felt-like triangular patch which stretches from the two ureters above to the urethra below, and is built up in layers like a venetian blind. It is formed by a fanwise extension from the dorsal walls of each ureter, and extends downward to form at least a part of the posterior wall of the urethra.

THE URETHRA

The urethra is a tubular extension of the bladder, which emerges from the bladder at a tangent. The angle thus formed between the bladder and urethra (the posterior urethrovesical angle) is important to the preservation of continence. It is kept intact when the pubovesical attachments of the urethra have their normal tone, but when they are torn or stretched, so that the urethra comes into line with the trigone, the angle is lost, and an important element in stress incontinence results.

Three urethral sphincters have been described —external, central and internal. The external sphincter is an arrangement of voluntary muscles of the usual circular type, and appears to be derived from the pubococcygeus muscles of the pelvic floor. The central sphincter is of uncertain value, and often is absent. The internal sphincter is one of the most important mechanisms for maintenance of continence.

It is composed of two loops of involuntary muscle which pass around the urethra so that they pull in opposite directions. One loop arises in the anterior wall and the other in the posterior wall of the bladder. The ends of each insert in the opposite wall. The anterior loop is lighter and more mobile, and is situated above the heavier and more stable posterior loop. When these loops are in their usual state of tonic contraction, they compress the urethra so that it is flattened, with the anterior and posterior walls apposed. The pubovesical muscles interdigitate with the anterior loop, and aid in closing the sphincter. When they are damaged, the sphincter may remain open, permitting passage of urine, especially under stress.

Closure by the sphincters is not complete enough to prevent all leakage, so an accessory mechanism comes into play to maintain secure closure—the venous pads. The submucosa of the urethra contains a system of venous plexuses which is cavernous in character. Distention of the bladder produces congestion in the capillaries of these venous pads so that they press on the mucosal folds, and aid the sphincters in maintaining snug closure of the internal vesical os. When the micturition reflex is initiated, decongestion of the venous pads occurs, releasing the pressure on the mucosa.

SUPPORTING STRUCTURES

The bladder and urethra are maintained in their normal position by the following structures: (1) The pubococcygeus muscles, which form a supporting floor for the pelvic organs. (2) The pubovesical muscles and ligaments which attach the urethra and bladder to the symphysis pubis. (3) The anterior vaginal wall, to which bladder

and urethra are closely attached. (4) A long ligament which parallels the anterior abdominal wall up to an attachment at the urachus.

THE MECHANISM OF MICTURITION

Voluntary relaxation of the pubococcygeus muscles is a necessary preliminary to micturition. This permits a downward and backward displacement of the bladder and internal os, which initiates a reflex involving the involuntary muscles. The bladder wall contracts and the pubovesical ligaments are stretched, relaxing the internal sphincter and obliterating the posterior urethrovesical angle. Simultaneously decongestion of the venous pads occurs, which increases the caliber of the urethra. When the bladder is empty, the process is reversed.

CAUSES OF URINARY STRESS INCONTINENCE

(1) Damage to the pubococcygeous muscles is the basic cause of incontinence.

(2) Resulting from it is uterine descensus and sagging of the anterior vaginal wall, with formation of cystourethrocele. Cystourethrocele is accompanied in about 40 per cent of the cases by urinary stress incontinence.

(3) Almost equally important is tearing or stretching of the pubovesical muscles and ligaments, which support the urethra and bladder and help to maintain closure of the internal sphincter.

(4) Loss of the posterior urethrovesical angle. In normal women, micturition obliterates this angle, but stress does not affect it. In stress incontinence, however, loss of the angle is a characteristic change.

(5) A brief involuntary downward and backward displacement of the bladder and internal os on stress, which initiates the micturition reflex. This displacement normally occurs on voluntary relaxation of the pubococcygeus muscles, but does not occur on stress unless there is damage to these muscles. Permanent downward displacement produces dribbling incontinence.

NONOPERATIVE TREATMENT

It has been estimated that 30 to 40 per cent of all women lack normal function of the voluntary muscles in the region of the vesical neck. Exercises have been devised which, used in conjunction with surgery, are reported to give better results than surgery alone. These exercises must be practiced for 20 minutes three times daily for at least six months. Good results have been reported in some 55 per cent of cases but exercises are not a substitute for surgery.

SURGICAL TREATMENT

During the past 75 years, four different surgical approaches have been made to the problem of stress incontinence, and in addition there have been many variants of each type of operation. Regardless of the approach, the significant effect in all of these techniques has been elevation of the urethra to its normal level, with restoration of the posterior urethrovesical angle.

First proposed was *urethral advancement*, in which the incision was periurethral, the urethra was dissected free, stretched, and elevated, and the external meatus was moved forward close to the base of the clitoris. In some of the techniques the bulbocavernosus, ischiocavernosus, or pubococcygeus muscles have been used to support the urethra. This operation has been revived recently, with considerable success. To us, however, it seems an unnecessarily complicated procedure, with distortion of the supporting muscles and displacement of the external orifice.

For some years the *sling operations* enjoyed great popularity. In these, various muscles, abdominal fascia, or fascia lata were used to support the urethra. Pedicled strips of rectus fascia were most often chosen. Bilateral tunnels were made, either behind the pubis or in front of it. The pedicled strips were brought down through one tunnel, passed beneath the urethra, and carried up through the other tunnel, then fixed to the rectus fascia under enough tension to support the urethra. These operations usually were successful, but they were formidable procedures.

A third approach, through the anterior vaginal wall, is the *plication operation*, in any of its several variants. Plication has been used primarily for repair of cystourethrocele, but is almost equally successful in curing the incontinence which accompanies it in 40 per cent of the cases. The bladder and urethra are dependent on the anterior vaginal wall for their posterior support. Sagging of the wall, therefore, promotes formation of cystourethrocele, and aligns the urethra with the trigone. This causes loss of the important posterior urethrovesical angle, one of the chief factors in stress incontinence. Plication of the musculofascial supports of the vagina, bladder, and urethra restores the parts to their normal position, and relieves incontinence.

The plication operation preferred by the authors (a modified version of Te Linde's technique) is as follows: An incision is made through the mucosa and musculofascia of the anterior vaginal wall. The musculofascia is first separated from the fascia surrounding the bladder and urethra, and then from the vaginal mucosa. The fascia of the bladder and urethra are plicated (as in a box pleat), and then the musculofascia of the vagina is closed as a separate layer. Any redundant tissue is imbricated for extra strength. The margins of the mucosal flaps are trimmed to fit the space, and the mucosa is closed. A size No. 28 urethral sound is introduced to assure a patent urethral canal. Five days later, after the catheter is removed, a sound is again passed.

Vesicourethral suspension (urethrocystopexy)

goes directly to the seat of the difficulty, and the procedure is relatively simple. In association with Dr. Irving Helfert, urologist, of Dayton, we have been using the Marshall, Marchetti, and Krantz technique with such satisfactory results that we feel it has been greatly undervalued.

The technique is as follows: A 30 cc. balloon, attached to a Foley catheter, is inserted into the bladder transurethrally, and the bag is inflated. With the patient in the reverse Trendelenburg position, the space of Retzius is exposed through a midline suprapubic incision. The bladder and urethra are separated from the posterior surface of the pubis and the rectus muscles down to one centimeter or less from the external urethral meatus. Three No. 1 chromic catgut sutures are placed at equal distances deep in the anterior vaginal wall, carried over the urethra, and inserted into the periosteum of the symphysis, preferably in the cartilage, then tied snugly. These sutures draw the anterior wall of the vagina, together with the urethra, upward and backward from the introitus. When necessary, two or three additional sutures may be placed through the wall of the bladder, then inserted through the rectus fascia, and tied. We seldom find them necessary, however. The space of Retzius and the abdominal incision are then closed.

This procedure eliminates cystourethrocele and suspends the urethra in its normal position back of the pubic symphysis. It restores the normal urethrovesical angle, and relieves stress incontinence in most cases.

The choice of operation is, we feel, a very important feature in success, and our preference in the indvidual case depends on a number of factors. In general, we would elect the Marshall-Marchetti technique (1) when the abdomen must be opened for other pelvic surgery, (2) when cystourethrocele has recurred after plication, (3) when a previous perineorrhaphy has narrowed the introitus so much that adequate space for a plication is lacking, (4) for nulliparous patients with a small vagina. Plication usually is our choice when the abdomen need not be opened, but other vaginal surgery is required.

RESULTS

Of 2,063 gynecological cases (1942-1953 inclusive), stress incontinence was present in 262 cases—1 in 8 (12.7 per cent). Of 649 plications for cystourethrocele, stress incontinence was present in 1 of each 2.5 cases (40.4 per cent).

Results of Plication: Symptom-free 198, improved 35, unchanged 10, worse 3, recurred 2, and not followed 14. In short, results were favorable in 89 per cent, unfavorable in 5.6 per cent, and unknown in 5.4 per cent. Reoperation in the two recurrent cases resulted in cure.

Results of 44 Vesicourethral Suspensions: Of these, we contributed 29 and Dr. Helfert 15. Dr. Helfert reports cures in 14 and failure in 1 because of postoperative hemiplegia. Of our cases, 25 are symptom-free, 2 are improved, and 2 are unimproved because of preoperative hemiplegia. Surgery seldom helps such patients, and they are a poor risk. Percentages in the 44 cases are as follows: Symptom-free 88.63, improved 4.55, and failure 6.82.

Comparable Results (per cent): Favorable: Plication 89.00, Vesicourethral Suspension 93.18. Unfavorable: Plication 5.60, Suspension 6.82. Unknown: Plication 5.40, Suspension none. On the whole, it appears, one type of operation is about as effective as the other, provided the cases are properly chosen.

This group of cases includes a considerable number of our early patients. With increased experience, we feel that our competence has increased proportionately, so that now we can expect a higher percentage of good results.

SUMMARY

The two fundamental causes of urinary stress incontinence are obstetrical injury to the pubococcygeus muscles or the pubovesical muscles and ligaments. Secondary to pubococcygeal injury are uterine descensus, cystourethrocele, and (on stress) a brief involuntary downward and backward displacement of the bladder and internal os which initiates the micturition reflex. Secondary to pubovesical injury are sagging of the urethra, loss of the posterior urethrovesical angle, and relaxation of the internal sphincter.

Urinary stress incontinence can be cured, in the great majority of cases by appropriate surgery. Four different types of operations have been used successfully, and in all of them the end result is elevation of the urethra and restoration of the posterior urethrovesical angle. Of the four types, we prefer a modified Te Linde plication and a modified Marshall-Marchetti vesicourethral suspension. In the former procedure, the fascia of bladder and urethra is plicated and the vaginal musculofascia is imbricated to restore normal support to the organs. In the latter, the urethra is suspended by suturing the anterior vaginal wall to the symphysis pubis and, if necessary, the bladder wall to the rectus fascia. Choice of operation depends on many factors, chiefly previous surgery or coincident vaginal or abdominal procedures.

Stress incontinence occurs in about 13 per cent of gynecological cases and 40 per cent of cystourethroceles. Results of our plications were favorable in 89 per cent, unfavorable in 5.6 per cent, and unknown in 5.4 per cent. Results in the Marshall-Marchetti vesicourethral suspensions were favorable in 93.18 per cent, and failure occurred in 6.82 per cent because of hemiplegia, which is a contraindication to surgery. On balance, in appropriate cases, one type of operation is about as effective as the other.

Diagnosis and Treatment of Fractures of the Zygoma

THOMAS R. LEECH, M. D., BRUCE C. MARTIN, M. D., and JOHN C. TRABUE, M. D.

IMPORTANCE OF EARLY RECOGNITION

EARLY recognition of fracture-dislocations of the zygoma is of prime importance in the final outcome of their treatment. Failure to restore the displaced bone to its normal position may result in disfigurements which will permanently alter the appearance and function of the face. Delays in treatment increase the difficulty of reduction and the possibility of complication. Extreme degrees of swelling and ecchymosis of the adjacent soft tissues can occur early making an accurate diagnosis difficult. For these reasons, we would like to discuss the diagnostic methods employed to determine the presence and extent of fracture as well as the management of these patients.

ANATOMICAL FRACTURES

Anatomically, the zygoma acts as a buttress protecting the orbit and its contents. The body of the zygoma is a strong solid structure resting on a tripod of its articular processes. These processes articulate medially with the maxilla, laterally with the temporal bone (forming the zygomatic arch), superiorly with the frontal bone and posteriorly with the sphenoid. Inferiorly is the thin membranous triangular process which joins with the maxilla to form the anterior wall of the antrum.

MECHANISM AND COMPLICATIONS OF FRACTURES

Fractures of the facial bones differ from most fractures because the displacement is due to the trauma itself rather than to muscular pull. The body of the zygoma is very rarely fractured as the force of trauma is transmitted to its weaker supports. Thus, if the force is sufficient to cause displacement it will produce fracture through the radiating processes as well as comminution of the triangular base support. (Fig. 1) With further increase in the severity of trauma fractures will extend through the body of the maxilla and the orbital floor. The next wave of force extends into the ethmoidal plate and nasal bones.

In addition to the displacement of the zygoma and the swelling and ecchymosis of the soft tissues several other events may and do occur. Most frequently there is some degree of injury of the infra-orbital nerve resulting in anesthesia over the side of the nose, adjacent cheek and upper lip. Diplopia may result from the downward displacement by lowering the outer canthus.

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Transient diplopia also may occur from contusion and swelling of the extra-ocular muscles. Occasionally, if the involvement of the orbital floor extends across the lacrimal bone, the inferior oblique muscle may be displaced. Cyclophoria then results because of intorsion of the eye by the unopposed action of the superior oblique muscle.

Further downward and backward displacement of the zygoma may impinge upon the coronoid process of the mandible interfering with its motion and producing clicking or trismus.

Very rarely the trauma may be severe enough

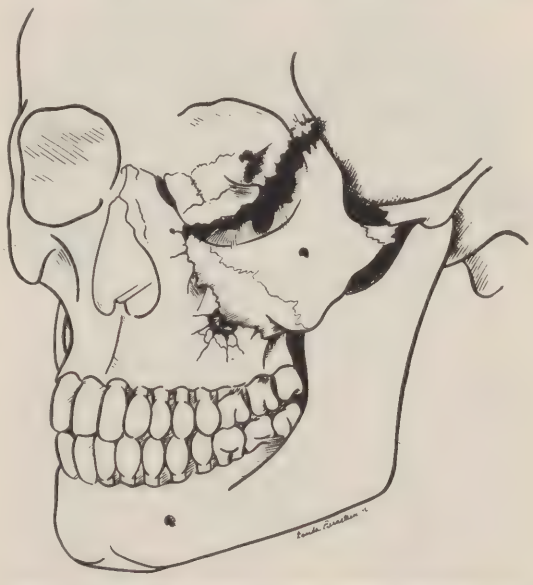


Fig. 1. Fracture-dislocation of the zygoma indicating the usual involvement of the radiating processes, the antral wall and the orbital floor.

to cause laceration of the oculomotor nerves and optic nerve.

EXAMINATION

Examination of the face requires nothing more than carefulness and completeness, following the rules of the general physical examination, i. e., inspection, palpation, percussion and auscultation. Primarily we depend upon inspection and palpation. By placing the patient in a chair and standing behind him (Fig. 2) these procedures become much easier. The head is tilted back slightly so that the infra-orbital area comes into view, and the contour of the injured side is compared to the uninjured side. Then, using the thumb and index finger, the infra-orbital ridge should be gently palpated, feeling for the "step" which is usually present when the zygoma is displaced. Similarly, the lateral orbital ridge and the zygomatic arch are palpated bimanually comparing the injured to the uninjured side.

Since the eye is the most important structure in this region it should be examined first. This examination is divided into two parts: checking the visual acuity and checking the extra-ocular movements. Visual acuity may be determined grossly by shielding the uninvolved eye and asking the patient what he sees. Should any abnormalities be encountered complete funduscopic examination should be done, preferably by an ophthalmologist. Disturbances in muscular balance producing diplopia may be determined by having the patient hold his head still and follow the examiner's finger or some object with his eyes through the full range of normal motion. Usually if diplopia is present, the patient will complain of it before being examined.

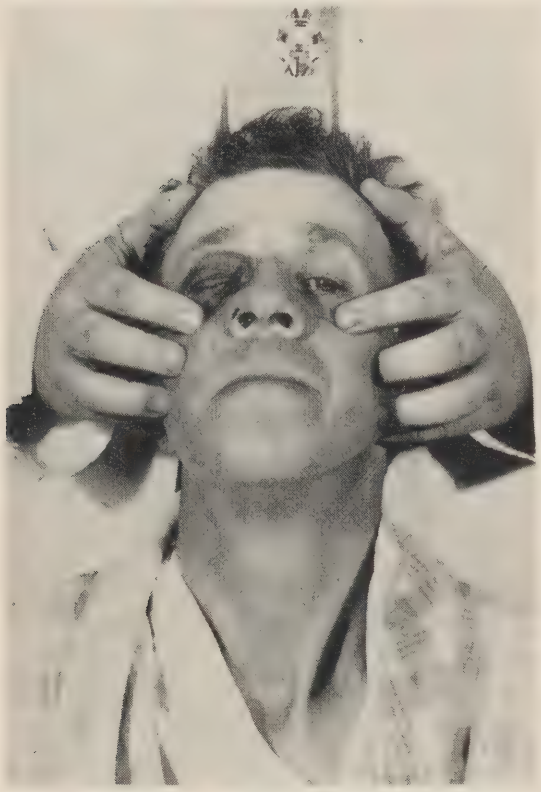


Fig. 2. Method of examination for fracture-dislocation of the zygoma with the head tilted back slightly and the examiner standing behind the patient.

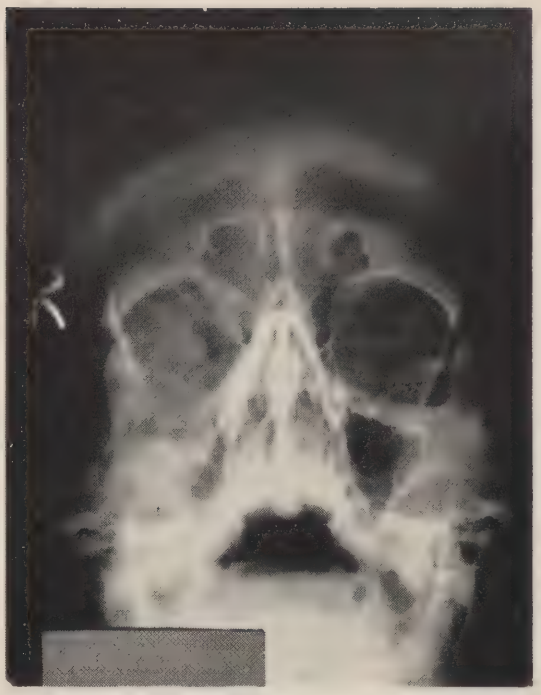


Fig. 3. Modified Water's view of the head showing fracture-dislocation of the zygoma. Note the step deformity of the infra-orbital ridge on the right, the separation at the lateral orbital rim and at the zygomatic arch.

Damage to the infra-orbital nerve may be demonstrated by light stroking of the infra-orbital area, side of the nose and upper lip. Numbness of these areas indicates that the nerve has been damaged but usually the extent of damage cannot be determined.

PLANNING OF TREATMENT

The degree of comminution, the amount of displacement and the presence or absence of blood in the antrum must be known to plan the proper treatment in each case. To determine these factors adequate x-ray examination is necessary. In addition to routine A-P and lateral views of the skull, a modified Water's view is most helpful as this plane projects the zygomas below the petrous ridge. (Fig. 3) Of further help is a stereoscopic series in this same position. For examination of the zygomatic arches, the submental-occipital view with the cone held close to the jaw to increase the distortion and thus throw the arch further out from the cranium is extremely helpful. (Fig. 4)

METHODS OF TREATMENT

Many methods have been devised for the reduction of fracture-dislocations of the zygoma and maintenance of position of the fragments.[1, 2, 3, 4] These may be divided into trans-antral and extra-

antral approaches. We prefer the trans-antral approach as first described by Lothrop[5] and modified by Caldwell and Luc. We prefer this method because it allows for (1) the evacuation of the antral hematoma, (2) the removal of the loose button of bone in the sinus, (3) adequate palpation of the orbital floor and zygoma, (4) the maintenance of the reduction of the fragments by a simple antral pack, and (5) prevention of infection by adequate drainage through the nasal window. If only the zygomatic arch is involved approach from above is preferred as described by Gillies.[6]

ANALYSIS

The incidence of fracture of the zygoma is rising with the ever increasing hazards of modern transportation. However, 40 to 50 per cent of these still occur around the home, office or factory due to falls, swinging doors or fisticuffs. It is in this latter group that the diagnosis may be missed because the patient had few complaints and the degree of trauma is minimal.

If a patient has sustained a blow to the cheek and complains of numbness of the lip or double vision, fracture-dislocation of the zygoma should be suspected immediately. Palpation of the infra-orbital area and x-ray examination as previously described will then support the diagnosis and treatment may be instituted. Some 10 per cent of these however will have no subjective complaints and the early swelling may obliterate the external appearance of bony deformity. In this group, elevation of the fracture is necessary so as to restore the bony contour of the cheek. If treatment is delayed beyond several days, reduction is more difficult and the incidence of complication increases. Complete fibrous union usually occurs within three weeks after which time it may be necessary to do such reconstructive procedures as cartilage or bone grafts to restore facial contour.



Fig. 4. Submental-occipital view of the head showing "figure 3" deformity of the right zygomatic arch.

For these reasons we feel the justification of this presentation. The best time to treat these fractures is as soon as possible. This then necessitates early recognition of the deformity which depends upon a careful and complete examination of the patient. A method of examination is described which will help establish the diagnosis even without the aid of x-ray examinations. X-ray examination is done to determine the extent of comminution and displacement even when the fracture is obviously present. This aids in planning the mode and extent of treatment.

CONCLUSIONS

In the six year period ending January 1, 1956, we have treated 81 patients with fracture-dislocation of the zygoma and 13 patients with depressed fracture of the zygomatic arch. Of this group, seven developed complicating features, only one of which was possibly due to the surgical procedure itself. This patient developed severe chronic maxillary sinusitis which necessitated a radical Caldwell-Luc excision of the antral mucosa.

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Carbon Monoxide Poisoning

Treatment: Immediately remove patient from exposure and keep in horizontal position: 1. Minimize oxygen demand. 2. Artificial respiration and oxygen therapy is immediately indicated if respiration is shallow. It is most urgent to prevent or abate anoxia! 3. Circulation may be improved by rubbing extremities. Keep patient warm and quiet. Avoid all strain. *Complete bed rest.* Be alert to a delayed relapse. 4. Whole blood transfusion by *exchange* is indicated in severe cases. —Sidney Kaye, Ph. D., Richmond, Va.: *Virginia M. Monthly*, 84:627, December, 1957.

Control of Fingers in Dermatology

HOWARD J. PARKHURST, M. D.

IN spite of the great advances in the field of therapy a few words on a commonplace subject may still be helpful. In the management of dermatologic cases, the importance of controlling the patient's fingers is too often overlooked. It deserves attention especially in the treatment of acne and the pyogenic dermatoses, and in many pruritic conditions.

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PYODERMAS

Patients with acne should constantly be cautioned to avoid touching the face and operating on the lesions. Even the removal of comedones should be forbidden; this should be done only by the physician, if at all. It is probable that infection can be conveyed by the fingers from follicle to follicle, producing new lesions. Excoriation aggravates scarring.

Obviously the fingers often cause the spread of furunculosis, folliculitis of the scalp, impetigo and ecthyma. Restraining measures may have to be used, especially during the night.

Many cases of contact dermatitis, especially those due to poison ivy, may be scratched and secondarily infected. Antipruritic applications should be used, and gloves worn during sleep to prevent excoriation.

VICIOUS CIRCLE

In eczemas at all ages, and especially in neurodermatitis, the vicious circle of itch-scratch-itch must be stopped, or the best treatment is likely to fail. This is also true in cases of senile pruritus, and pruritus ani, vulvae and scrotalis, in which the avoidance of scratching is of paramount importance. Many women present a thickened pruritic patch inside the occipital hair border, and here the frequent use of an antipruritic ointment and strict avoidance of scratching will usually bring a quick cure.

The patient should always be instructed to keep hands off, because it is true that many skin conditions do not itch until they are touched. If itching occurs, antipruritic medication may be applied to relieve it. To prevent nocturnal scratching the patient must wear thick, smooth cotton gloves during his sleep. There must be no rough outer seam on the glove fingers, and they must fit the hands so that they will not be removed during the night. An antipruritic ointment or lotion should be at the bedside for immediate use if itching awakens the patient.

Infants with eczema should have *two* thick cotton stockings fastened over *each* hand, *night and day*, and secured to the sleeves with two stout safety pins. This affords 2-ply protection; one stocking would not be enough. It does not limit motion of the arms, and seems to give satisfactory results.

SUMMARY

To sum up: Patients with acne must never touch the affected areas. The same is true of pyogenic dermatoses.

In all itching skin conditions, smooth cotton gloves should be worn during the night and effective antipruritic applications provided for use when needed. Scratching must be avoided at all times.

In infantile eczema the hands should be covered constantly.

The Harmful Effects of Oxides of Nitrogen

The irritant oxides of nitrogen, especially nitrogen dioxide (NO_2) are liberated during gas-shielded electric arc welding and when organic nitrogenous materials are heated. Fires in chemical laboratories often result in breaking of bottles of nitric acid, with liberation of nitrogen dioxide from the heated liquid. Proof that "silo disease" is due to oxides of nitrogen is still lacking, but the evidence is strongly convincing. The fatal concentration is 150 to 200 ppm if breathed for an hour; 30 ppm will produce symptoms and 5 to 10 ppm is considered safe for an eight hour working day. At a distance of six inches from the welding field the concentration may reach 30 ppm but at two feet it is rarely 1 ppm. Los Angeles air contains at most 0.5 ppm and the peak concentration on most days rarely is above 0.25 ppm.

The harmful effects of the oxides of nitrogen are similar to those of ozone, but except at fatal concentrations, symptoms and signs are delayed for several hours, whereas with ozone the effects may be noted almost at once. The chief effects are upon the pulmonary epithelium, with ensuing edema and even hemorrhage; this is followed by fibrotic changes which develop to the point of respiratory embarrassment in three to eight weeks. Such fibrosis can probably be ameliorated or prevented by administration of Meticorten.®—Clinton H. Thienes, M. D., Pasadena: *California Med.*, 87:135, September, 1957.

Eye Care in Nursing

WILLIAM H. HAVENER, M. D.

EVERY nurse working in a hospital will encounter patients who cannot adequately close their eyelids. Such a patient is subject to the serious hazard of corneal damage from exposure and drying. Among the more common diseases which may cause corneal exposure are unconsciousness from trauma, the coma of serious illness, the lethargy of sedatives and anesthetics, and paralysis of the facial nerve (which innervates lid closure). Obviously there are very many such patients, and the potential incidence of corneal exposure damage is therefore very great.

Because of the nature of her duties, the nurse is in far more constant and close attendance upon the patient than is his physician. Her alertness is the patient's first defense against many threats while he is in a helpless condition. The importance of specifically guarding against corneal exposure is well illustrated by the following two cases:

Case No. 1: The 32 year old wife of a physician developed a very severe pneumonia, which caused her to lie semicomatose with partially unclosed lids during one night. Thanks to modern antibiotics she made a complete recovery—*except for permanent scarring of both corneas* as a result of that one night of exposure and drying. Permanent blurring of vision (20/200) is surely a high price to pay for a single unguarded night.

Case No. 2: A 27 year old nurse with a parotid malignant growth underwent surgery, which included removal of the facial nerve. Being at the end of a long day's schedule, she was returned directly to the floor in the evening instead of to the recovery room. Semicomatose during that night and unable to close her lids on the paralyzed side of her face, she developed severe exposure damage and scarring of the involved cornea; and to this day cannot see even the big E on the vision chart.

Tragically unnecessary, isn't it? The simplest of care—liberal use of any lubricating eye ointment and careful lid closure will prevent occurrence of similar tragedies. Nurses, in their routine nursing rounds, are the best insurance against corneal exposure—if they will be constantly alert for those lids which are not adequately closed.

Administration of eye drops is perhaps the commonest ophthalmic medical care carried out by nurses. This is most simply done by having the patient look up (turning both face and eyes upward) as the nurse retracts the lower lid downward. This creates a pocket behind the lower lid into which medication can easily be dropped. Normal blinking and eye movements will promptly distribute this medication over the surface of the eye.

An important precaution frequently overlooked is avoidance of contamination of the dropper (or nozzle of the tube, if ointment is used). Should the dropper touch the patient's lids, the nurse's fingers, the table, etc., it will carry bacteria to the bottle. The next drop from this bottle will then deliver germs to an eye. It is authoritatively believed that a significant percentage of eye infections arise from the use of contaminated drops from dispensary, hospital, or office. Even antibiotic drops may carry serious infections, since no antibiotic is effective against all strains of bacteria. *Do not*, therefore, permit an eye dropper to touch the lids or any other surface.

Be absolutely certain what kind of drops was ordered, and recheck the label before use to avoid error. Very serious consequences may ensue from such a mistake. As an example, let us select atropine, a commonly used drop which dilates the pupil and paralyzes accommodation —sometimes for as long as two weeks. The mistaken use of a single drop of atropine in a patient with glaucoma may precipitate an acute elevation of intraocular pressure, requiring surgery and perhaps even costing the patient his sight. If a neurosurgical patient suddenly develops dilated and nonreactive pupils, brain surgery may be recommended if the physician is unaware that atropine has been mistakenly used. I have seen a nurse unable to read for a week because of rubbing her eyes with a finger contaminated with atropine.

Manipulation of the lids during instillation of drops or for inspection of the eye should be done with fingers placed over the bony walls of the orbit. *Never* attempt to open lids by pressing over the eyeball itself. This is especially true in the care of postoperative intraocular surgical patients. Industrial nurses, called upon for first aid in eye injuries, should scrupulously avoid pressing upon damaged eyes. A single enthusiastic, but misguided, squeeze on the lids may

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pop lens, iris, and vitreous through a corneal laceration more easily than squeezing a blackhead!

Since the postoperative care of intraocular surgery is usually limited to eye floors, it will be discussed only in broad terms. Whenever an incision has entered an eye, the hazards of rupture of the wound, prolapse of intraocular contents, and intraocular hemorrhage exist. Incidence of such serious complications rises sharply if the patient is uncooperative, or is handled roughly. Immediately postoperatively the utmost gentleness is mandatory, and any muscular exertion or jarring of the body must be avoided. Strict bed rest is observed, turning is permitted only with help, meals should be fed by an attendant, and the patient should be *lifted* onto the bedpan. The operated eye should be protected from accidental injury by a metal shield. There is no objection to careful hair-combing or shaving by an assistant, providing the patient's head is not shaken.

A warning is in order concerning the care of the nurse's eyes. Dealing constantly with disease and infection, she is ideally situated to carry bacteria to her own eyes. A nurse should *never rub* or pick at her eyes unless she has washed her hands thoroughly. A nurse can get conjunctivitis just as easily from an abdominal abscess as from another infected eye. Should infected matter spurt into her eye, prophylactic use of topical antibiotics is definitely indicated, under supervision of an ophthalmologist.

Acute bacterial conjunctivitis (pink eye) is the commonest cause of a red eye, and is a relatively benign disease. The importance of redness as a warning signal of eye disease should not be underestimated, however; *redness, pain, and decreased vision* in an eye demand prompt attention. Such manifestations occur in corneal ulcer, iritis, glaucoma, and similar extremely serious eye diseases.

Will reading in bed damage the patient's eye? Or holding the book too close? Or using the poor light of the bedside lamp? Or reading without his glasses which he forgot to bring to the hospital? Or excessive T. V. watching? No evidence exists that any eye damage can result from these practices. It is certain that prolonged use of the eyes under adverse conditions may lead to fatigue, even headache, but this does not injure eyes any more than legs are injured by walking upstairs till they are tired. Even in the presence of eye disease, use of the eyes is not harmful (with the exception of some cases of strabismus and retinal detachment). It is sad to hear of blind patients who have denied themselves the pleasure of seeing while they could with the erroneous idea of "saving their eyes."

Glasses are useful primarily for the symptomatic relief of such symptoms as headache, eye fatigue, or decreased vision. With the exception of strabismus, eye disorders are not made better or worse by wearing or not wearing glasses. A brief mention of glasses dispensing is in order because of common confusion concerning personnel in this field.

An ophthalmologist (or oculist) is an M. D. who has taken additional specialized training in eye care, presently requiring three years beyond internship. He is qualified in all aspects of eye care, including surgical, medical, and refractive problems.

The optometrist is a nonmedical man, formerly often self-trained, now graduating from a college course. He is qualified to measure the refractive error of eyes, but is not trained to diagnose or treat any type of disease—ocular or systemic.

An optician is the technician who prepares and grinds lenses, places them in proper frames, and otherwise carries out the mechanical manufacture and fitting of glasses.

With great frequency both ocular and systemic diseases manifest themselves through visual disturbances and eye fatigue. The patient has no way to differentiate these symptoms from those of refractive error. Should he seek aid from a nonmedical refractionist, diagnosis of the true nature of his difficulty and proper treatment are often considerably delayed. Common diseases with such ocular manifestations include diabetes, hypertension, intracranial pathology, and blood dyscrasia. As one example of an eye disease with such manifestations we may select chronic simple glaucoma.

Chronic simple glaucoma affects 2 per cent of all people over 40 years of age. It is an extremely insidious, difficultly recognized, almost asymptomatic process which is responsible for 12 per cent of all blindness in the United States today. Masquerading as the need for a new pair of glasses, glaucoma may successfully deceive the patient and his refractionist until the white-cane phase of this disease nears. Anyone over 40, with any history of familial blindness due to glaucoma or unknown cause, should consult an ophthalmologist.

One other serious eye problem of high incidence should be mentioned. About 2 per cent of the population has one eye with vision so poor as to be essentially useless—due to an entirely preventable cause. Suppression amblyopia refers to poor vision due to disuse of an eye. The common cause of this is strabismus (cross-eyes) in childhood. The simple expedient of patching the good eye (under expert supervision) during childhood can force the suppressed eye to see again. Such therapy must be instituted early to be successful. Any child with strabismus should be seen by an ophthalmologist *as soon as strabismus is noted*, regardless of how young the child is. A particularly pernicious old wive's tale runs thus, "Never mind, he'll outgrow the cross-eyes." It is true that a number of cases with crossed eyes may spontaneously straighten, but suppression of vision in an eye will never clear without ther-

apy. In fact, if vision has not been restored by 6 years of age, it is probably lost forever.

To summarize I urge that nurses always follow these rules:

1. Never let your patients suffer from corneal exposure.

2. Always check order and label to be sure you have the right kind of drop.

3. Never contaminate the dropper.

4. Manipulate lids by pressure over the *bony rim* of orbit, never over eyeball.

5. Be gentle with postoperative intraocular surgical patients.

6. Don't rub your eyes.

7. Red, painful eyes with decreased vision demand prompt attention.

8. Two per cent of everyone over 40 has chronic simple glaucoma, the cause of 12 per cent of blindness in the U. S. A. Everyone over 40 with a family history of blindness due to glaucoma or unknown cause should consult an ophthalmologist.

9. A cross-eyed child should consult an ophthalmologist as soon as this condition is recognized.

Epidemiology of Q Fever In Man

Though Q fever unquestionably can be transmitted by means of insect vectors and by means of contaminated milk or other food products, these methods have given a poor yield of transmission experimentally. Similarly, epidemiologic information indicates that these methods are not significant. By far the most successful method of transmitting the disease experimentally has been by exposure to dust contaminated with the organism.

A study of most human epidemics substantiates the impression that the disease is generally transmitted by airborne modalities. Clinically, the disease does not seem to be transmitted from person to person, and isolation of patients is unnecessary. In Iowa, one would expect to find Q fever in farmers who work with or in the vicinity of cattle, sheep and goats, and it would be most apt to occur in the spring following delivery of the young animals. It is also likely to occur in employees of meat packing and rendering plants, or in personnel who handle hides and skins. Finally, it is exceedingly likely to occur in any laboratory working with Coxiella burnetii. In almost every instance, some personnel or individuals having casual contacts with such a laboratory become infected.

The disease is much more common in men than in women, and much more common in adults than in children. Perhaps the explanation is to be found in the fact that men are more frequently exposed to animals and their dust.—Robert E. Hodges, M. D., Iowa City: *J. Iowa State M. Soc.*, 57:696, November, 1957.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on November 20, 1957, at 12 o'clock noon. There were three cases presented.

Case 47: A 30 year old patient. September, suspicious Papanicolaou smear. Cervix described as having marked erosion, friable to touch and bleeding readily on examination. November Papanicolaou smear negative. March Papanicolaou smear positive. Patient admitted to hospital. Biopsy specimen taken. Carcinoma in situ was revealed. Patient treated by total abdominal hysterectomy. Follow-up examination in November revealed no evidence of disease.

Comments: Seven months' institutional delay. Suspicious Papanicolaou smear followed by a negative. Papanicplaou smear is of no significance in presence of an abnormal cervix. Biopsy should have been done at least at the time of the second smear.

Case 48: A 55 year old patient. Postmenopausal bleeding for four years. Increased bleeding from January till June. Treated with vaginal suppositories for a period of one year. June dilatation and curettage revealed carcinoma in situ of endometrium. Patient treated by total abdominal hysterectomy.

Comments: *Patient delay* three years. *Physician delay* one year. Vaginal tablets therapy is incorrect treatment for post menopausal bleeding.

Case 49: A 50 year old white female asymptomatic until three months prior to admission to the hospital. Developed tightness of her clothing and an enlarged abdomen. When first aware of symptoms she saw her physician.

Laparotomy revealed nonoperable ovarian carcinoma. Patient treated with external therapy.

Comments: Three months' delay on part of the patient. This case points up the absolute need of periodic pelvic examination. It is the only manner by which ovarian carcinoma can be detected early other than abdominal surgery.

Convalescence and Rehabilitation Following Head Injury

The convalescence and rehabilitation of the head-injured is usually smooth and complete considering the severity of the alteration of brain function that occurred. Pending litigation, a neurotic personality and advanced age are operative in delaying a course of otherwise uneventful recovery, however. The recent tendency to advocate an earlier ambulation and assumption of activity with return to a useful role in life is based on sound principles, and contrasts with the time-honored period of enforced absolute bed rest for the most trivial head injuries, which together with an alarmist and overprotective supervision, often bred much psychosomatic invalidism.—Juan E. Fonseca, M. D., Tucson: *Arizona Med.*, 14:651, November, 1957.

Acute Hydramnios at the Fifth Month of Pregnancy (Report of a Case)

R. R. MAIER, M. D.

AN intriguing problem for obstetricians for many years is the origin and fate of amniotic fluid. Recently, Hutchinson et al.[1] using radioactive isotopes, confirmed the theory that the fluid and the electrolytes are in a constant state of exchange with the mother. But in spite of such advances in our knowledge we are still in the dark as to the true source of the fluid and, hence, as to the etiology of the syndrome of acute hydramnios. A short time ago, I encountered such a problem which merits reporting because it presents a typical picture and involves a truly excessive quantity of fluid.

CASE REPORT

The patient, a 29 year old female, Para II, gravida III, had an uneventful previous obstetrical history, having had two normal full term male infants with no complications in 1950 and 1952. On March 31, 1953, she presented herself with a story of having had her last menstrual period on November 28, 1952. Examination disclosed the uterus to be enlarged to the level of the umbilicus, which was much higher than one would have anticipated from the date of her last menses. Laboratory studies showed her to be Rh positive, serologically negative for syphilis, and moderately anemic with a hemoglobin of 62 per cent and a red blood cell count of 3,420,000. Urine was normal, blood pressure 120/70, weight 127 pounds.

When again seen on April 18, 1953, her weight had jumped to 133½ pounds, her abdomen appeared to be the size of a 7 month gestation, and she now had pedal edema. Hydramnios and twins were suspected and x-ray confirmed the latter.

She was started on a regime of restricted fluid intake, sedation and ammonium chloride (90 grains daily). But the patient showed no improvement and, by May 2, her weight had increased to 137½ pounds. She had constant abdominal pain and dyspnea to such an extent as to interfere with her eating and sleeping. She was approaching exhaustion. Hospitalized on May 4, the restricted regime was augmented by bed rest and the use of Demerol® for her pain.

The laboratory findings showed a marked secondary anemia (hemoglobin 6.9 grams and 3.24 million red blood cells). The uric acid was 5.8 mg. per 100 ml. which was slightly elevated. A urea clearance test on May 5 revealed a better than average normal function and chest plates disclosed neither pleural nor pericardial fluid. In spite of the restricted regime and an apparently greater fluid output than intake, she gained almost 2 pounds. She lost her pedal edema but her abdomen was tremendous.

Insofar as she was in only her fifth month and her exhaustion and debility were so marked as to render it impossible for her fetus to reach a period of viability, let alone term, it was decided that some form of tapping must be undertaken. Since pelvic examination showed the cervix to be effaced and about 4 cm. dilated, it was felt the safest procedure would be needle puncture of the membranes and gradual release of the fluid. Under direct vision, a small trocar was introduced through the membranes and a measured 9,000 cc. of amber-colored fluid were withdrawn.

Almost simultaneously with the loss of the fluid, uterine contractions began and, within a matter of minutes, one twin presented as a double footling breech. The patient was given cyclopropane anesthesia and the first twin extracted. Considerable bleeding followed its delivery, apparently from a partial separation of the placenta, so the second twin was quickly delivered by version and extraction and the placenta manually removed. Pitocin® was given intravenously and ergotrate intramuscularly; the distended uterus contracted quite well. Her blood pressure remained good, but in view of her anemia, she was given a transfusion of 500 cc. of whole blood. The infants, both females, made a few attempts at respiration and then expired. Twin "A" weighed 390 grams and "B" 420 grams.

The mother's postpartum course was entirely uneventful and by her first postnatal visit on May 28, 1953, her weight was down to 111½ pounds. The patient subsequently became pregnant again, had an entirely uneventful pregnancy, and delivered a normal infant on July 5, 1955.

DISCUSSION

This case, as pointed out, met all the requisites for acute hydramnios as set forth by Yordan and D'Esopo. There are, however, several unusual features. First, it presented a full blown picture extremely early, well before the twentieth week of gestation. Second, the quantity of measured fluid (9,000 cc.) approached the upper limit of that reported in the literature. Third, we were fortunate in our handling of the problem that the fairly rapid emptying of the uterus did not give rise to atony, hemorrhage or shock. Fourth, it would seem that the twin pregnancy was somehow related to the etiology, since the same patient subsequently had a completely normal single gestation.

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From the Division of Obstetrics and Gynecology, Mount Sinai Hospital of Cleveland.



TOPIC THIS MONTH:

Maternal Deaths* Involving Anesthesia

CASE NO. 7

The patient was a 31 year old, colored, Para III, abortus I, who died 10 hours and 41 minutes postpartum. The past medical history revealed no significant findings and the prior obstetrical history likewise did not contribute any pertinent data other than that her first two pregnancies at ages 18 and 26, respectively, resulted in uncomplicated, live, term deliveries. Her third pregnancy at age 28 terminated as a 10 week abortion.

The antenatal course from the sixth month of gestation, when the patient first came under the supervision of the attending physician for her last pregnancy, was reported as adequate with a record of eight prenatal visits and no pathological findings were noted at time of any of these prenatal visits.

On January 28 the patient entered the hospital at term in active labor; Demerol,® scopolamine, and Nembutal® analgesia was administered. After a 10 hour and 14 minute labor, membranes were ruptured artificially followed in 15 minutes by low forceps delivery of a living 10 pound, 6½ ounce fetus. It was reported that during the second stage, when the patient became restless on the delivery table and could not be controlled by nitrous oxide-oxygen-ether anesthetic, she was given 5 cc. of 2½ per cent sodium Pentothal® solution intravenously with subsequent signs of aspiration and apnea. Following suction aspiration, she seemed to improve and following the delivery she was taken to her room in fair condition.

Her condition remained fairly stable with the use of oxygen and sedation. Details of the physical findings are not recorded. She was reported as "suddenly becoming acutely ill and died within a few minutes in spite of heroic efforts of resuscitation." Autopsy was not performed.

Cause of Death: Aspiration of vomitus; anesthetic for delivery.

COMMENT

The Committee voted this a preventable maternal death and felt that this case emphasized the importance of insuring beforehand that the stomach be empty before a general anesthetic is administered. The Committee felt the situation was poorly handled after vomitus was aspirated. It would appear that in such a case bronchoscopic aspiration of the trachea and upper bronchial tree would be in order.

CASE NO. 13

This patient was a 22 year old, white, Para I (twins) who died 18 hours postpartum. Her past history included only an appendectomy in 1948. She registered October 13 (at 19 weeks) and returned for regular visits thereafter; early nausea and vomiting with one episode of pedal edema were her sole prenatal complications. Her pelvis was considered adequate; total weight gain was 19 pounds.

On February 10 (36 weeks) at 1 a. m. she was admitted to the hospital, in labor, with normal findings on physical examination, cervix 4 cm. dilated. Demerol 100 mg. and scopolamine 1/100 gr. were administered at 2:30 a. m. For nearly 12 hours labor stopped, then recommenced at 1 p. m. (Feb. 10) when the medication was repeated. Intravenous fluids were administered, labor continued. By 12:45 p. m. (Feb. 11) the cervix was completely dilated, head at plus 1 station; Demerol 100 mg. was given. She was taken to the delivery room, given ½ cc. of Nalline,® and a saddle block anesthetic was administered (5 mg. Pontocaine,® and 1 cc. of 10 per cent dextrose).

Immediately the patient complained of vertigo and nausea, when horizontal; no blood pressure could be obtained. Oxygen was started and ½ cc. epinephrine (1/1000) was given intravenously followed by 1000 cc. of 5 per cent dextrose in water. The patient was prepared and draped. At 1 p. m. Baby "A" (4 pounds, 12 ounce) was delivered alive by low forceps; the patient responded only slightly. Epinephrine was repeated. Blood pressure varied 110/70 to 0/0. Baby "B" was then delivered at about 1:15 p. m.? (weight not recorded) as a stillborn, by version and breech extraction; placenta was complete at 1:55 p. m. February 11th.

After the second twin, the patient's blood pressure was 80/0, respirations were normal and she was lucid; she was maintained on Neo-Synephrine.® Legs were elevated, 400 cc. 5 per cent dextrose in water was given, followed by 1,000 cc. dextran and 1,000 cc. whole blood. She seemed to improve. Blood pressure was 90/0, pulse 100 and a retention catheter was placed, draining a small amount of urine.

Obstetric consultation was obtained at about

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

6:30 p. m. and an abdominal binder was placed. Soon acute pulmonary edema, and cyanosis developed; morphine ¼ grain was administered followed by 1/6 grain more in 30 minutes, and Cedilanid.® At 11:30 p. m. a "grand mal seizure" developed followed by cyanosis and the blood pressure disappeared. Treatment included Levophed,® 100 cc. of 20 per cent dextrose in water, then 300 cc. of 20 per cent dextrose in water followed by adrenal cortical extract. The patient deteriorated, pulse disappeared, and after another convulsion she expired February 12 (18 hours postpartum). Autopsy permission was obtained:

Pathological Diagnosis: Severe cerebral edema; severe pulmonary edema; patchy hemorrhagic necrosis of liver; membranous glomerulonephritis, mild upper nephron nephrosis; bilateral hydrothorax; (Note: clinical history and course would suggest mechanism of shock following tetracaine injection. While latter is a possibility it can be neither confirmed nor denied).

COMMENT

With a great deal of interest the Committee studied the well organized report of events in this case. Apparently the diagnosis of twins was made soon after delivery of Baby "A" which is not too unusual, but it shocks the operator. It was felt that medication during labor was too heavy, and that entirely too much parenteral fluid was administered after delivery. Rather, a needle should have been inserted to run fluids intravenously *prior* to injection of the spinal anesthetic, thereby being ready for the hypotension which followed. Some members felt it would have been helpful to drain spinal fluid when shock developed. All members agreed that it would have been advisable to *treat the patient* in her profound hypotension, rather than to have traumatized her and the fetus (es) with prompt delivery, especially with version and extraction. The Committee voted this a preventable maternal death.

CASE NO. 36

This patient was a 32 year old Negro, abortus I, Para VII, who died almost 15 minutes postpartum. Family history and her past history were not remarkable. Her first pregnancy (twins) terminated at six months; the following five pregnancies were delivered at term without complication. Her last menstrual period began August 16th, and the prenatal course was uncomplicated until the eighth month, when she developed a transverse lie. This was corrected by external version; pelvic measurements (clinic) were reported to be adequate.

On May 5th (at term) the patient was admitted in active labor at 11:15 p. m. Examination revealed blood pressure 120/90, pulse 86, respirations 18; heart and lungs were clear, abdomen 27 cm., fetal heart good, fetus presented as a breech (obliquely), membranes intact and bulging, cervix fully dilated. Fifteen minutes later it was decided to proceed with a vaginal delivery under general anesthesia.

At 12:15 a. m. (May 6) the anesthesia was begun (nitrous oxide, oxygen and ether) by a physician. As the patient was being prepared, she vomited and aspirated a large amount of undigested food. Attempts were made to suction patient; because of the tremendous amount of material filling the pharynx a nasal tube was passed. Breathing ceased and the patient's pulse became weak.

Even though a tracheotomy was done, no oxygen passed into the lungs. Immediately the patient was delivered, breech extraction, 6 pound, 1 ounce, lethargic baby which responded to gentle stimulation; a "nuchal hitch" developed but was decomposed by rotation. The mother did not breathe and was pronounced dead at 12:30 a. m. Autopsy was performed.

Cause of Death: Asphyxia, aspiration.

Pathological Diagnosis: (Coroner) Air emboli in inferior vena cava and ventricle and atrium of right heart.

COMMENT

The Committee voted this case a preventable maternal death. Members noted the similarity between this case and Case No. 12 (Maternal Health in Ohio, *Ohio State M. J.*, 52:1298, (Dec.) 1956). Although some agent was indicated in this breech delivery, inhalation anesthesia should not have been employed unless it was certain that the stomach was empty. Committee members felt that pudendal block would have provided a safer anesthesia, under the circumstances; or perhaps she needed none at all.

COMMENT OF CONSULTANT

The following comment of a consultant, who is a specialist in Anesthesiology, was given at the request of the Committee.

* * *

The comments of the committee are pertinent and this consultant is in full agreement with them. Supplementary remarks follow.

Physicians may well be proud of the great improvement in medical care which is taking place in this country. As maternal mortality from all other causes decreases, the proportion of maternal deaths due to anesthesia is increasing. The hazards of anesthesia today are identical with those of years gone by: aspiration of vomitus, obstruction of respiration, and shock.

Physicians have become so accustomed to the excellent anesthesia and profound relaxation available for surgical patients, that similar conditions are sought for obstetrical patients. That the risk factors in obstetrical patients are greater is not sufficiently taken into account.

Year after year, a high proportion of all anesthetic deaths is caused by the aspiration of vomitus. A number of things could be done to reduce the frequency of this catastrophe:

1. Emphasize to your patients that when labor begins they should not eat or drink.

2. Do not give food or fluid by mouth to patients in labor in the hospital. Record on the chart when the last meal was eaten.

3. Do not administer general anesthesia to any patient whose stomach is likely to contain food. Use regional anesthesia: local infiltration

of the perineum, or pudendal block, or caudal, or spinal.

4. If a general anesthetic must be given to a person known to have ingested food recently, the stomach may be at least partially emptied by the administration of apomorphine or other emetics.

5. If a general anesthetic must be administered to a patient who has food in her stomach, an endotracheal tube should first be inserted under topical anesthesia. This will prevent the aspiration of vomitus.

RESPIRATORY EMERGENCY

When a respiratory emergency develops under general anesthesia, tracheotomy often takes too long; consultation, regardless of how erudite, is usually too late. Prompt intubation of the trachea is the preferred treatment. If aspiration of vomitus occurs, the trachea and bronchi should be cleaned, using an endotracheal tube or a bronchoscope. Restlessness of the patient is probably a sign of anoxia. It should be treated by more oxygen and more suction of the respiratory tract, rather than by sedation, which contributes to anoxia and may result in death by respiratory depression.

Following the development of respiratory obstruction or aspiration of vomitus, patients usually have increased respiratory effort for a few moments. During this period the pressure in the pleural space becomes strongly negative. This negative pressure is transmitted to the veins, and may result in air being sucked into the open venous sinuses of the postpartum uterus, or into any other veins which have been traumatized, such as those in the tracheotomy site. Air embolism does not occur often; postpartum women are among those who are prone to develop it.

HYPOTENSION

An extraordinarily high anesthetic level may develop following saddle block anesthesia. Hypotension and paralysis of respiratory muscles develop; both result in hypoxia but death need never occur. Proper treatment of such a complication consists of: administration of oxygen (assisted or artificial respiration) to raise the tension of oxygen in the alveoli, and administration of vasopressor drugs in exactly controlled quantities to support the circulation. The vasopressor drugs should preferably be given in an intravenous infusion (Neosynephrine® 5 mg. or ephedrine 100 mg. in a liter), thus permitting moment to moment control of the blood pressure by regulating the speed of the infusion. The administration of repeated doses of large quantities of vasopressor drugs causes transient hypertension followed by a return to the hypotensive state. During the hypertensive period a cerebral vascular accident may occur.

Neurogenic hypotension following spinal anesthesia does not require fluids for treatment. The hypotension is brought about by dilatation of the blood vessels, and the aim of treatment is to cause the blood vessels to regain their normal tone. The intravenous infusion is merely a vehicle for the controlled and continuous administration of the vasopressor drug. Fluids in great quantities, particularly colloidal fluids such as dextran and blood, cause a marked increase in the work of the heart, and may lead to congestive failure.

PULMONARY EDEMA

The treatment of pulmonary edema caused by excessive fluid administration should consist of phlebotomy, the placement of tourniquets around the extremities, and the administration of oxygen with positive pressure. Alcohol vapor should be added to the oxygen for the purpose of decreasing the surface tension of the edema fluid, thus permitting better aeration of the lungs. Administration of digitalis to a patient with an otherwise normal heart should not be relied upon. The use of large quantities of narcotics in such instances should be avoided. Immediately following delivery or operation, patients are unusually susceptible to the depressant effects of narcotics.

Complications may develop following the administration of any type of anesthetic. Minor complications frequently go unrecognized; major complications often result in a fatality. The incidence of both may be decreased by proper selection of patients and skillful administration of the anesthetic. Whoever administers an anesthetic should not only know the possible complications, but should understand their physiologic basis, and be equipped for and skilled in their treatment.

Viral and Rickettsial Infections Treated with Reticulose

The most noteworthy finding as a result of this study (of five clinical cases of acute viral syndromes) is the rapid action of Reticulose® in promoting a remarkable therapeutic response, particularly after the lack of beneficial action of various chemotherapeutic agents and antibiotics.

Reticulose was well tolerated by all of the five patients and produced no evidence of toxic manifestations or side effects. None of the patients exhibited any sensitivity or allergic reactions while in the hospital or during their convalescence following their discharge.

There was no discomfort elicited after the intramuscular injections. In all of the patients there was improvement within 24 to 36 hours after Reticulose was started, which was manifested by clinical and symptomatic improvement. —Robert H. Anderson, M. D., and Ralph M. Thomspon, M. D., Alexandria, Va.: *Virginia M. Monthly*, 84:347, July, 1957.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

PRESENTATION OF CASE

THIS 59 year old man entered University Hospital, Columbus, complaining of nocturia and burning on urination. He had had two transurethral resections elsewhere three and two years ago for benign prostatic hypertrophy. He was seen at the genitourinary clinic one week prior to admission, where cystoscopy could not be performed due to a severe stricture of the penile urethra, which allowed only 1 inch of the cystoscope to be introduced. Two or three days prior to admission he noticed bilateral costovertebral angle tenderness associated with chills and fever. He denied hematuria, dribbling, urgency and incontinence.

Four years ago the patient was in an automobile accident and sustained a "back injury" without demonstrable fractures. Three years ago he had attacks of "asthma." He was accustomed to drinking up to a pint of whisky a day. He had had exertional dyspnea and pedal edema for the past three or four years. There was marked wheezing with paroxysmal nocturnal dyspnea. Three months ago he had a "heart attack" characterized by syncope, without pain. He was hospitalized elsewhere for 10 days and was treated with oxygen during the first 24 hours. Review of systems was otherwise noncontributory.

PHYSICAL EXAMINATION

The temperature was 100.2° F., pulse 104, respirations 32 and blood pressure 180 over 95. The patient was a well developed white male, mildly dyspneic and hyperpneic, with wheezing. He was in no acute distress. Auscultation showed bilateral wheezing throughout the chest with dullness on percussion noted over both bases. The left heart border was percussed at the anterior axillary line. He had a grade III high-pitched, whistle-like murmur over the pulmonic valve area. There was a sinus tachycardia.

The abdomen was slightly obese and pendulous. The liver edge was palpated 5 fingerbreadths below the right costal margin. There was epigastric and costovertebral angle tenderness. The spleen was not palpable. There was shifting dullness on percussion. The genitalia were normal. There was 2 plus pretibial edema.

LABORATORY FINDINGS

His red blood count was 3.34 million, his hemoglobin 10.6 Gm., his white blood count 5,250 with a normal differential count. The urinalysis showed a specific gravity of 1.012, a *p*H of 7.5, a protein of 75 mg.; the sediment showed many bacteria (rods and cocci). The serology was negative for syphilis. The alkaline phosphatase was 7.7 units, inorganic phosphorus 3.2 mg., the acide phosphatase 0.4 units. The blood cholesterol was 165 mg., the cholesterol esters 67 per cent; the cephalin flocculation reaction was 3 plus; the direct van den Bergh 1.0 mg., the indirect 2.1 mg.; the thymol turbidity reaction 50; the prothrombin time 34.6 per cent. The blood urea nitrogen was 26 mg. The sodium was 145 mEq., the potassium 4.7 mEq., the blood chlorides 110 mEq.; the Co_2 combining power was 40 to 56 volumes.

X-RAY EXAMINATION

The x-ray of his chest on admission revealed cardiomegaly and calcification of the aorta with signs of moderate congestive failure. An intravenous pyelogram showed functioning kidneys with poor visualization of the collecting system. The bladder showed an unusual pattern possibly due to trabeculation. The spleen was enlarged.

ELECTROCARDIOGRAM

The electrocardiogram showed a pulse rate of 100 with a regular sinus rhythm. The P-R interval was 0.16; the QRS wave was 0.08; the ST and T waves were normal. The impression was left ventricular enlargement with premature ventricular contractions.

HOSPITAL COURSE

Immediately after his admission to the Urological Service the patient was transferred to the Medical Service. He was digitalized and given ammonium chloride and mercurials. He lost 5 pounds in four days. Later he became confused and the lumbar puncture showed a pressure of 220 mm., a sugar of 83 mg., and chlorides of 727 mg.; the bacteriological examination was negative. The blood urea nitrogen rose to 48 mg. Because of slight elevation in his blood ammonia, chloral hydrate and ammonium chloride were discontinued. His blood urea nitrogen fell to 35 mg. and his weight stabilized. The Bromsulphalein® retention was 46.5 mg. and electrophoretic studies showed an albumin of 49.8 per cent and a

Presented by

- S. W. Robinson, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.

globulin of 50.2 per cent with 29.1 per cent of gamma globulin.

Three weeks after his admission he suffered two bouts of epistaxis. The patient was again transferred to the Urology Service and had several urethral dilatations until a No. 16 catheter could be passed. He was transferred back to the Medical Service and one week later again had severe epistaxis arrested only by cauterization and packing.

Immediately after this he went into shock with hyperventilation, a blood pressure of 70 over 30, a pulse of 120. He was treated with dextran and whole blood. Despite two blood transfusions he again became confused, lethargic and shocky. His blood pressure fell to 80 over 40 and his pulse rate rose to 120. He appeared acutely ill. The sclerae were moderately cyanotic; hydration was fairly good; cardiomegaly was noted again and a loud, blowing, harsh systolic murmur over the apex; both lungs showed rales on auscultation. The neurological examination revealed a cloudy sensorium but was otherwise not remarkable. A repeat electrocardiogram showed an atrioventricular block, left ventricular stress and digitalis effect.

He was given 3,000 cc. of intravenous fluids, calcium gluconate and sodium glutamate. Under this treatment his hemoglobin rose to 9.6 Gm. He continued to run a fever between 100 and 103° F. A blood culture was reported positive for enterococcus. He was given massive doses of antibiotics including penicillin, erythromycin, and several blood transfusions.

He developed increasing weakness, became uncooperative and disoriented, and had a few bleeding episodes from the rectum which were attributed to hemorrhoids. He also developed attacks of asthma which responded to epinephrine. He had persistent tachycardia with frequent extrasystoles, a positive Duroziez's sign and a pistol-shot sound over his femoral arteries. The heart dullness extended to the anterior axillary line and a loud, harsh sytolic murmur was heard frequently over the apex in the fifth intercostal space. Along the left sternal border a medium-pitched diastolic murmur could be heard in the third and fourth intercostal spaces.

The spleen extended two to three fingerbreadths below the left costal margin and the liver two to three fingerbreadths below the right costal margin. His pulse rate decreased to 60 with occasional bigeminy, and he became semi-stuporous and disoriented. He had a clonic-tonic seizure, fell into deep coma and expired after a hospital stay of three months.

CLINICAL DISCUSSION

DR. S. W. ROBINSON: Since I can see no possibility of explaining all the findings of this patient by a single diagnosis, I shall attempt to separate the several problems involved in this patient's final illness. His present illness began three to four years ago with attacks of asthma, and then we may assume that he developed some mildly progressive congestive failure, although we do not know how much this interfered with his normal activity. Apart from this he also had his urinary tract problems, which were quite obvious at the time of admission. He had had two prior transurethral resections and so we can assume that he had had some type of obstructive uropathy without any evidence of unilateral renal disease. In addition he showed symptoms of alkalosis, such as his wheezing, which I do not consider as part of his congestive failure. There was finally the additional problem of gastrointestinal bleeding which seems to be ascribed to bleeding hemorrhoids. And, finally, we have some evidence that this patient was also suffering from some type of liver disorder which may or may not be part of his congestive failure.

Let us discuss first his urinary tract lesion, because I don't think that it had any serious relationship to his demise. I think we can assume that he was suffering from benign prostatic hypertrophy. He also had a urethral stricture which had to be dilated, and he probably had bilateral pyelonephritis. He showed evidences of proteinuria and bacilluria, but there is nothing to suggest that he had renal insufficiency at the time of his admission although he did have a transient rise in his blood urea nitrogen during a period of time when he was in shock.

What other genitourinary lesions may he have had other than benign prostatic hypertrophy with some uropathy and a secondary mild pyelonephritis? Maybe this man had prostatic carcinoma and we are just being misled by the back injury four years ago. Or perhaps he had a multiple myeloma in one of his lumbar spines which caused symptoms simply by being jarred by the accident. I think that we can probably dismiss these possibilities since his acid phosphatase was less than 1 unit and there is nothing to suggest myeloma except his mild anemia.

The next thing I wish to discuss is his heart disease. Does he have heart disease complicated by respiratory disease? Or did he have basic primary respiratory disease that led to heart disease? I would prefer the first assumption for the following reasons: He had a history of three years of asthma which apparently could be satisfactorily controlled by medication. In association with his wheezing respiration he also developed basilar rales or basilar congestion. But during this three-year period, during which he was developing the symptoms of his terminal illness, he showed exertional dyspnea apart from his wheezing with pedal edema and paroxysmal nocturnal dyspnea. He had a "painless heart attack" for which he required oxygen. Another good evidence in defense of the diagnosis of primary heart disease is his hypertension present at admission, which probably had existed for some

time and which only disappeared when he went into shock.

THE ENLARGED HEART

Clinically and roentgenologically he had a big heart, involving particularly the left ventricle, and he never showed cyanosis except during one attack of vascular collapse. He had this interesting high whistling murmur heard over the pulmonic area and later developed a soft diastolic murmur. He was given diuresis, placed on digitalis, and got along well for a matter of four or five days, at which time he developed some mental confusion. Since he was on ammonia products and since his blood ammonia was just above the upper limits of normal, we may relate this confusion simply to ammonia retention. He had a loud blowing systolic murmur at the apical area. He had bilateral rales. His liver again was noted to be sensitive but at this time he did not have peripheral edema.

We will assume that he was maintained on digitalis and was probably being periodically given diuresis during this period of five weeks. The electrocardiogram showed an A-V block, some evidence of left ventricular strain and of digitalis medication, but it did not show any evidence to suggest myocardial injury. His final phase of illness is characterized by fever, confusion and increasing congestive failure. He suddenly had a convulsive seizure, took a few gasps and died.

If we are going to assume that he had primary heart disease with an additional separate problem of lung disease, I think that it would be correct to state that he had hypertensive heart disease which might have been contributed to by his urinary tract problem. He had a large left ventricle. His promiment harsh systolic murmur suggests an aortic stenosis, but he probably did not have a sufficient degree of aortic stenosis to keep his blood pressure at a lower level. We know that sometimes it is difficult to be certain of the physical findings of aortic stenosis and that the murmur is not necessarily located over the aortic area where we would traditionally expect to find it. I think that sometime in the fifth week of his illness, when he developed sudden epistaxis and later went into shock, he showed the first clinical evidence of the development of subacute bacterial endocarditis, since he went through a period of febrile illness which was not mentioned before that time.

Did he also have mitral valve disease? It would be hard for me to say, but I simply choose to select only one valve as being involved although I recognize that that is not a particularly safe position to be in. Once he developed subacute bacterial endocarditis it probably affected his valve further so that he was then having a to-and-fro murmur from his aortic valve. It is attractive to speculate if he might have had a fenestrated perforated aortic cusp, but I don't believe that the man went into sufficiently profound and sudden failure and that the harshness of his diastolic regurgitant murmur was sufficiently characteristic for a ruptured aortic valve leaflet.

Now I think that his lung disease was independent of his heart disease and that it may have been no more than a senile emphysema or chronic bronchitis.

THE LIVER

Finally, we must discuss his liver condition. From the history we know that he liked his whisky in reasonable amounts and with regularity. We are also told that he had a large palpable liver five fingers below the costal margin, but we do not know anything about its consistency or the contour of its free margin. Subsequently the clinical reports suggest splenomegaly which was not present at the time of his admission. The problem of gastrointestinal bleeding enters into the picture also, which might be attributed to liver disease. His stupor, which we explained as a consequence of ammonium chloride therapy, could also be of hepatic origin.

The high Bromsulphalein retention at a time when he had adequate diuresis also supports the diagnosis of liver disease and the rationale of prescribing sodium glutamate might have been with the idea of combating hepatic insufficiency. We see no evidence of palmar erythema or any of the other stigmata that might suggest cirrhosis. But I still lean toward cirrhosis on the basis of his Bromsulphalein retention and his abnormal blood proteins manifested by the cephalin flocculation, the thymol turbidity tests, his prothrombin time and his electrophorectic pattern.

Finally, a note concerning his alkalosis. It is noted that his carbon dioxide combining power was consistently high and on one urine examination his urine *p*H was 7.5. This man was hyperpneic most of the time and I choose to believe that he probably had a respiratory alkalosis.

Why did he die? Did he die because he slowed his pulse even more and had a Stokes-Adams episode at this time? Did he die as result of embolization at this time? Did he die because he developed a fatal ventricular fibrillation or some other fatal rhythm disturbance? Of those three possibilities I do not know what happened. I am inclined to believe that he died as a result of embolization.

CLINICAL DIAGNOSIS

1. Hypertensive and rheumatic heart with calcific aortic stenosis and acute bacterial endocarditis.
2. Nutritional liver cirrhosis.
3. Prostatic hypertrophy with obstructive uropathy and chronic pyelonephritis.

PATHOLOGICAL DIAGNOSIS

1. Hypertensive and rheumatic heart disease with aortic and mitral valvulitis and acute bacterial endocarditis.
2. Nutritional liver cirrhosis with portal

hypertension, ascites and secondary hypersplenism.

3. Benign nephrosclerosis and chronic pyelonephritis.

4. Obstructive uropathy due to urethral stricture and previous prostatic hypertrophy.

PATHOLOGICAL DISCUSSION

DR. EMMERICH VON HAAM: This case was presented because of the multiplicity of clinical symptoms. He was the kind of fellow that you will meet quite frequently in your practice—a hard-drinking, hard-working man who does not complain much and who, as he gets older, develops liver cirrhosis and prostatic hypertrophy, and due to the stress and strain of business life, hypertension.

The autopsy showed a well developed, poorly nourished male with mild jaundice and pitting edema of his lower extremities. His peritoneal cavity contained 600 cc. of clear fluid. Each pleural cavity contained about 500 cc. of hemorrhagic fluid. His heart was large and weighed 600 grams. The left ventricle was dilated and its wall was thickened. The mitral valve appeared nodular. The aortic valve appeared thickened and calcified. The valve was covered with friable vegetations and one cusp of the valve appeared perforated.

The lungs appeared heavy and congested. The spleen was large and weighed 600 grams. The liver was decreased in size, firm and nodular. No esophageal varices were found but the hemorrhoids were prominent and congested. The kidneys appeared large and coarsely granular. The bladder wall was thickened and trabeculated. Most of the prostate had been removed. The brain appeared congested and edematous. The right frontal lobe contained a cystic space filled with soft creamy material.

MICROSCOPIC EXAMINATION

Section through the aortic valve showed extensive fibrosis with calcium deposits and a superimposed acute purulent inflammation with the formation of ulcers covered by bacteria-laden thrombotic vegetations. Sections through the mitral valve showed similar changes but to a much less degree and without calcification. The lesion presented the typical picture of acute bacterial endocarditis superimposed upon old rheumatic valvular heart disease and involved the aortic valve much worse than the mitral. Sections through the heart muscle showed some perivascular fibrosis but no recent inflammation suggestive of myocarditis or pericarditis. The aorta showed rather severe atheromatosis. The lungs were congested and edematous with numerous heart-failure cells and small infarcts. The patient must have had severe circulatory anoxia before he died.

THE LIVER SECTIONS

Sections through the liver showed marked nodularity with fatty changes and broad fibrous septa typical of a nutritional cirrhosis with portal hypertension. I would say that he had plenty of functioning liver tissue left and certainly should not have suffered from hepatic failure. The esophagus did not show any varicosities but his portal hypertension undoubtedly could have been responsible for the increased hemorrhoidal bleeding. The spleen showed fibrosis of the pulp with nodular reticulum-cell hyperplasia and the pulp cords were packed with red and white blood cells. The picture was typical of the secondary hypersplenism found in younger individuals with portal hypertension and could have been responsible for his anemia, mild jaundice and relatively low white blood cell count. It is an unusual finding for a patient of this age.

Sections through the kidneys showed mild benign nephrosclerosis with some chronic inflammatory changes indicative of pyelonephritis. The cortical zones of the adrenal glands were broad and the cells appeared loaded with lipoid material. These changes explain well the hypertensive state of the patient. The muscle of the bladder was hypertrophied and sections through the urethra showed scar tissue with stenosis. The brain lesion proved to be an old infarct of his frontal cortex and may explain some of his confusion blamed by Dr. Robinson on his ammonia intoxication. It can be explained as a result of embolism from his heart disease.

In summary then, I would like to say that our autopsy findings confirmed to a remarkable degree the clinical diagnosis put forward by Dr. Robinson and I want to congratulate him on his clear and concise analysis of the complex picture presented by this patient.

Vertigo May Incapacitate The Patient

The term vertigo is being used in a broad sense to include the generally accepted forms: the subjective form, in which the patient seems to revolve in space; the objective form, in which the world moves about the patient; and the less definite type called giddiness or dizziness. In the latter form may be included those cases caused by cerebral ischemia as they are often referred to by the patient as being within the head.

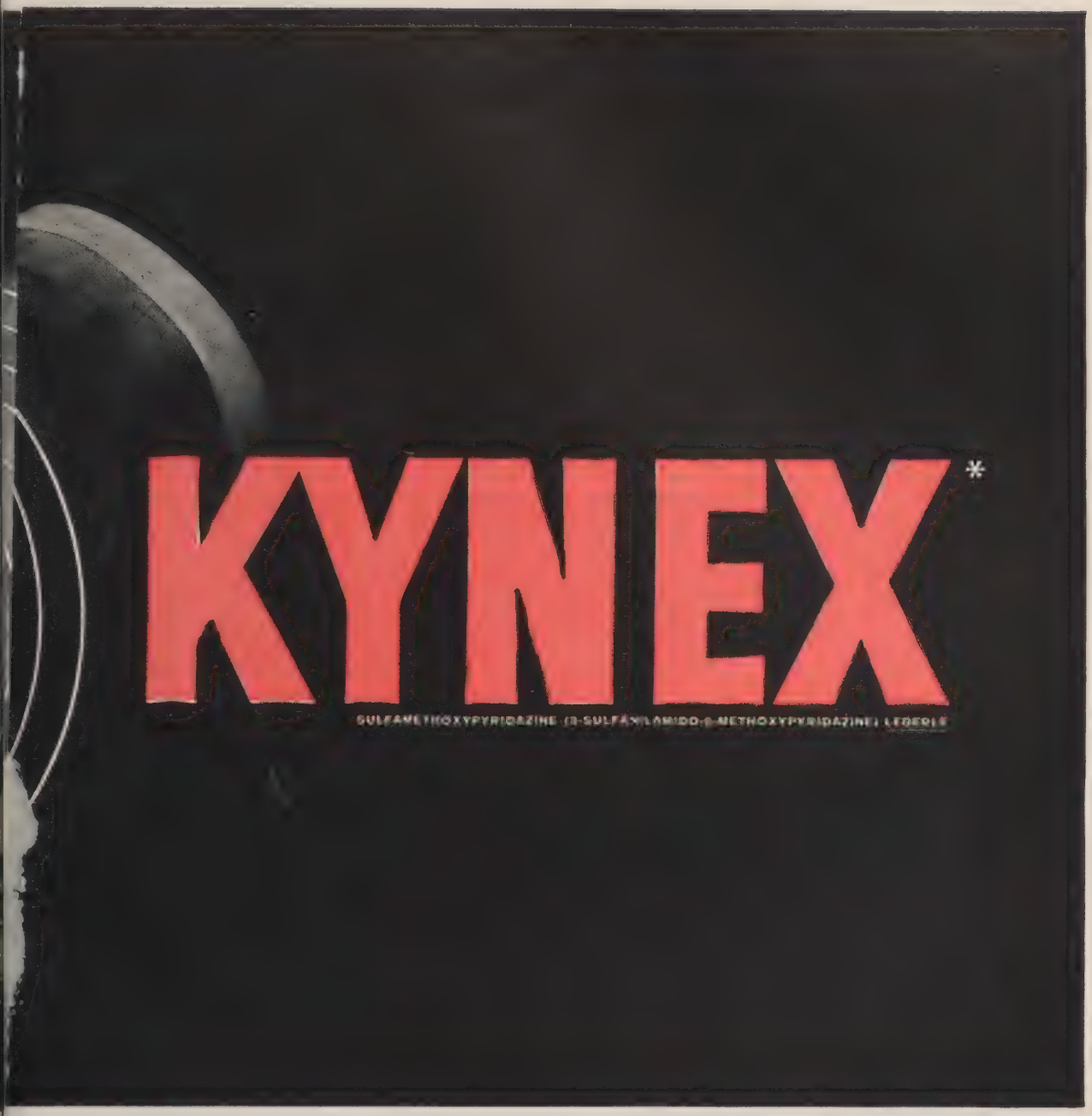
The vertigo may be only occasional, or it may be severe enough to incapacitate the patient. It may occur only on motion. Like other symptoms, it is intermittent in time and variable in intensity. Atkinson states that disturbances which produce the characteristic vestibular and cochlear manifestations of Ménière's syndrome are not confined to the ear alone, but there is a general disturbance which involves other organs and functions.—A. O. Hendrickson, M. D., and W. O. Hendrickson, M. D., Wausau, Wis.: *Wisconsin M. J.*, 56:357, September, 1957.



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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.



NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

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Clinical Laboratory Services . . .

This Specific Instrument Is Necessary for Diagnosis and Treatment Of Hospital Patients, the Joint Commission on Accreditation States

AVAILABILITY of good clinical laboratory services is an important item for each hospital to consider. This article, which is another in a series on hospital accreditation, consists of a statement on this subject issued by the Joint Commission on Hospital Accreditation.

* * *

To provide quality care for patients in hospitals, scientific tools are a necessity for both diagnosis and treatment. Although the extent and complexity of these facilities depend upon the needs of the patients whom the hospital aims to serve, no hospital can be without basic laboratory and radiological services.

In every hospital there should be a well organized, adequately supervised clinical laboratory with the necessary space, facilities and equipment to perform those services commensurate with the hospital's needs for its patients.

GOOD PERSONNEL NECESSARY

Good personnel and supervision are very important factors. It would be ideal if every hospital had its own pathologist. This is impossible because the demand is greater than the supply. Also, the amount of work in smaller hospitals does not justify the full time services of a pathologist. The Joint Commission on Accreditation of Hospitals believes strongly that if a hospital does not have the full time services of a pathologist, it should at least have the services of a pathologist on a regular part time or consultative basis. A hospital is not criticised for sending tissues out to a pathologist but if that same hospital has not been visited by or had its laboratory supervised by a pathologist for quite a long period of time, it must of necessity be scrutinized very carefully as to quality of service given.

The employment of technicians registered by the American Society of Clinical Pathologists is a factor in evaluating quality of laboratory services. Here again the actual number employed means very little without taking into consideration the type of work performed. Very frankly, however, a hospital without the services of a pathologist and without registered technicians cannot objectively be regarded as giving quality care.

RECORD KEEPING

Besides supervision and competence of personnel, the hospital laboratory is evaluated on the basis of the adequacy, speed and completeness of its laboratory service. All reports should be signed and filed in the patient's record. Duplicate copies should be filed in the laboratory. A tissue file and index should be maintained in every hospital laboratory. This index should be according to pathological diagnosis. Whether this index be simple or comprehensive is a question of judgment of the hospital and its needs.

Oral requisitions for laboratory work are not condoned. Requisitions may be made out by the nurse, but there should be an original order for the procedure, signed by the physician. This order should either be on the patient's medical record or in the physician's order book.

MINIMAL REQUIREMENTS

In order for a hospital to be accredited, the Commission requires that a urinalysis and either a hemoglobin test or hematocrit determination be done on all patients admitted. These are minimal requirements and in many instances should be exceeded. Additional requirements should be recommended and approved by the medical staff. The Commission has no requirements concerning laboratory work on outpatients. These policies should be determined by the local medical staff.

In a modern hospital, it is desirable that the hospital have a blood bank, established and supervised under strict regulations. Where this is not possible, the hospital should have at least proper blood storage facilities under adequate control and supervision. For the patient's safety these storage facilities should have an adequate alarm system, notifying hospital personnel of loss of electric power or faulty temperatures.

AUTOPSIES

The percentages of autopsies performed and their utilization as a teaching medium is a very important factor in the accreditation of a hospital, and of necessity is closely allied to the pathology department. The actual procurement of permission for autopsies is largely a function and responsibility of the medical staff. An autopsy should be performed by a pathologist, but where this is not possible, the next best person is a physician versed in autopsy procedure and protocol.

Every good hospital should have its own morgue if physically possible. The number of hospitals without morgues is quite high and the number not doing autopsies is considerable. Autopsies, as a means of staff education and improvement of clinical knowledge, rank extremely

high in the minds of the Commissioners of the Joint Commission. As a rule of thumb, the Commissioners believe that non-teaching hospitals should have at least a 20 per cent autopsy rate and teaching hospitals at least a 25 per cent rate. Many good physicians feel this rate is too low and every effort should be made to exceed it.

EQUIPMENT

Attention has been called recently to the necessity for checking the calibration of special laboratory instruments and equipment regularly and periodically. Faulty thermometers and inaccurate colorimeters have been reported in several instances in hospitals. Further checking showed they had not been checked since placed in service.

Where possible, the hospital pathologist should be a member of the tissue committee, preferably in an ex-officio, consultative capacity. The question has been frequently asked, "Should the pathologist be a member of the medical staff, entitled to vote and hold office?" The answer to this question is not within the jurisdiction of the Joint Commission on Accreditation of Hospitals and is a matter of judgment for each individual hospital. It can be stated from observation and information from most hospitals, that the answer is preferably 'yes' and is done in the majority of hospitals.

EDITOR'S NOTE: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. In previous issues, the following phases of the subject were discussed: August—principles underlying the work of the accreditation commission; September—recommendations of the AMA Stover Committee; October—medical staff meetings; November—medical records; December—responsibilities of the medical staff. This is the sixth article in the series.

In subsequent articles as information is available *The Journal* will present suggestions and information from the Joint Commission and answers by the Commission to many varied questions on the activities of the Commission, standards set, hospital administrative problems, etc.

Name Director of Ohio Cancer Division

Dr. Arthur G. James, president, American Cancer Society, Ohio Division, Inc., announced that J. P. Kalina, of Cleveland, has been appointed managing director of the Ohio Division to succeed the late L. E. Herget. Mr. Kalina was assistant managing director and director of field activities for the Ohio Division for the past 12 years.

Doctor's Right To Collect For Services Limited By Time

The following interesting article appeared in a recent issue of the *Cleveland Academy of Medicine Bulletin.* It was written by Mr. Baruch A. Feldman, L. L., B., member of the law firm of Feldman & Feldman:

The physician's right to recover compensation for services rendered does not live indefinitely. After a specified number of years, the right to recovery is barred by various statutes of limitations. In non-legal language, the claim is said to have become outlawed.

Where services are rendered without a written contract and where no promissory note is received by the physician, the claim of the physician is barred six years after the services are rendered or six years after the last payment on account has been made.

In instances where services are rendered by virtue of a written agreement and in instances where the patient has delivered a promissory note to the physician, the physician's claim will not be barred until fifteen years after the date of the contract or of the promissory note.

It is sometimes difficult to determine when the six-year period, which will bar the claim, commences to run. Generally, where charges are made for the treatment of one condition, such as pneumonia, the six-year period commences to run on the date that the last item of service was rendered. Where several items of service are rendered for different conditions or for different members of a family, the statute of limitations commences to run for each item of service on the date that such item of service was rendered.

When his claim has become barred by the statute of limitations, the physician can no longer recover a judgment for his services. This is true even if the patient admits that the services were rendered, admits that the services were satisfactory, and admits that the charge was reasonable. All that the patient need to do to defeat the physician's claim to plead the statute of limitations. The court, thereupon, must dismiss the physician's case.

The physician need not permit his claim to become outlawed. He may keep it alive by suing his debtor before the statutory has run and by securing a judgment against him. This judgment may be kept alive indefinitely.

The periods of the various statutes of limitations are not criteria of the times when accounts should be submitted for collection. These statutes merely fix deadlines after which claims become unenforceable. The exact time at which an account should be submitted for collection depends on the particular circumstances of the case. The size of the claim, the relationship between the physician and the patient, the relationship between the physician and the patient's family, the physical and the financial conditions of the patient are elements to be weighed.

Rural Health Committee . . .

Arrangements Are Being Completed for Altered Lecture Program for Medical Students in Addition to Expanded Preceptorships in 1958

THE Committee on Rural Health is completing arrangements for its 1958 preceptorship program in June, anticipating an expanded scope after the outstanding success of the 1957 program, first of its kind in Ohio.

Again in 1958, students at the University of Cincinnati School of Medicine who have completed their junior year will spend two weeks with general practice preceptors in small communities and rural areas. Purpose of the program, according to Dr. E. K. Yantes, Wilmington, is "to teach the students medicine as a way of life." Dr. Yantes is chairman of the Rural Health Committee.

REPORTS ENTHUSIASTIC

The 1957 program drew enthusiastic reports from the students, their preceptors and several Ohio newspapers. Also, the Council commended the committee for this and other activities at its September meeting, and unanimously approved an expanded 1958 preceptorship program.

While the scope last June was purposely limited because of the fact that it was the first year for this activity, the number of preceptorships requested by the students far exceeded the number provided. The committee plans to offer more than double the number next June.

ANNUAL LECTURES

The committee also is completing arrangements for its annual talks to medical students at Cincinnati, the Ohio State University College of Medicine and Western Reserve University's School of Medicine.

A format different from the usual series of six weekly meetings will be tested at Ohio State and Cincinnati in February. At those two schools, a one-day program consisting of an afternoon of panels and speakers with the regular dinner in the evening is scheduled. It is believed the students will find this type of meeting more valuable than the weekly meeting since the latter comes at 5 p. m. on a weekday, a time when medical students are ready for dinner and a "break" rather than another hour of lecture.

MORE PRACTICAL PLAN

Also, particularly at Cincinnati, many medical students have full or part-time jobs that interfere with their attendance at extra-curricular weekday meetings.

The one-day meeting at Cincinnati is scheduled for 1:30 p. m. Sunday, February 9, at the Netherland Hilton Hotel. The Ohio State meeting is scheduled for 1:30 p. m. Saturday, February 15, at the Ohio Union.

At Western Reserve, weekly lectures are scheduled for 5:15 p. m. Wednesdays, March 5, 12, 19, 26 and April 2 and 9, the last meeting being the dinner session.

PRESIDENT TO SPEAK

Speakers for the dinner meetings at all three schools will be President Robert S. Martin, Dr. Yantes and Mrs. V. R. Frederick, Urbana, Auxiliary president.

Still another change in the lecture programs is being made at Cincinnati. Previously, the lectures were for seniors at Cincinnati and Ohio State, and Juniors at Western Reserve. The Cincinnati faculty pointed out that the lectures probably would have more impact on Cincinnati juniors. As a result, juniors and seniors are being invited to the forthcoming lectures there, and the 1959 lectures will be directed to the juniors.

Academy of General Practice To Meet in Dallas, Texas

The American Academy of General Practice Tenth Annual Scientific Assembly will open March 24 in the new Dallas Memorial Auditorium. More than 90 scientific and 300 technical exhibits will supplement the scientific lecture program.

Special activities are planned for the Academy's tenth anniversary Assembly. Tuesday, March 25, will be Dallas Southern Clinical Society Day. The DSCS meeting, held each March in Dallas, has this year been combined with the AAGP Assembly.

The Academy's Congress of Delegates will convene on Saturday, March 22. All sessions of the Congress and many social functions will be held in the Statler Hilton hotel.

Pavick Named Labor Representative On Industrial Commission

Governor C. William O'Neill has appointed Michael J. Pavick as Labor representative on the State Industrial Commission succeeding Will T. Blake, Labor member, who resigned by reason of poor health. Mr. Pavick is an Akron attorney and former Assistant Attorney General during the tenure of Governor O'Neill in that office. He is 34 years of age and a graduate of Ohio State University College of Law. This appointment is for the unexpired term of Mr. Blake, ending on June 30, 1959.

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The 1958 ANNUAL MEETING

Ohio State Medical Association

April 15-17

Cincinnati

THE NETHERLAND HILTON HOTEL
Headquarters and Scene of Most Features

Here are features of interest to physicians . . . specialty section programs in which 14 Sections participate . . . Several of these are joint or combined programs to give various slants on the subjects discussed . . . General Sessions at which topics of interest to physicians in all branches of medicine will be presented . . . The Scientific and Educational Exhibits, always interest-drawing features of the annual meetings . . . The Annual Banquet, social highlight for all Ohio physicians and their ladies . . . The Technical Exhibits . . . meetings of the House of Delegates . . . separate meetings of the Woman's Auxiliary . . . Specialty Society meetings . . . Alumni and other organization functions . . . A truly composite program for all Ohio physicians.

Synopsis of Program, 1958 Annual Meeting, Ohio State Medical Association, Cincinnati, April 15-17

MONDAY, APRIL 14

First meeting of the House of Delegates following dinner for those attending in official capacity.

TUESDAY, APRIL 15

Morning Features:

Registration opens 8:30 a. m.
Scientific and Technical Exhibits open 9:00 a. m.

Section Meetings: 9:30 to 11:00 a. m. and 11:30 to 12:30:

Joint Session, Sections on Anesthesiology and Otorhinolaryngology.
Section on Industrial Medicine.
Section on Obstetrics and Gynecology.
Joint Session, Sections on Pediatrics and Radiology.
Section on Urology.

Afternoon Features:

General Session—"The Doctor and His Taxes."
Symposium on Fractures.
Exhibits open continuously until 5:30 p. m.

WEDNESDAY, APRIL 16

Morning Features:

Scientific and Technical Exhibits open 9:00 a. m.

Section Meetings, 9:30 to 11:00 a. m. and 11:30 to 12:30:

Combined Session: Section on General Practice
Section on Internal Medicine
Section on Radiology
Section on Surgery

Joint Session: Section on Nervous and Mental Diseases
Section on Physical Medicine

Section on Neurological Surgery
Section on Ophthalmology

Workshop on Medical Writing

Afternoon Features:

General Session—
Address by Dr. F. J. L. Blasingame, new General Manager of the AMA.
Presentation "The Doctor Defendant."

General Session— "Unfruitful Pregnancy"
"Ophthalmoscopic Findings in Relation to General Medicine."
(Third topic to be announced)

Meeting of the Ohio Psychiatric Association

Exhibits open continuously until 5:30 p. m.

Evening:

The Annual Banquet.

THURSDAY, APRIL 17

Morning Features:

Final Business Session of the House of Delegates following breakfast for those attending in official capacity.

Scientific and Technical Exhibits open 9:00 a. m.

General Session:

Symposium on "The Treatment of Common Dermatological Problems."
Symposium on "What's New?"

Afternoon Features:

General Session—Panel Discussion on "The Acute Abdomen."

Exhibits open continuously until 3:30 p. m.

APPLICATION

For Space in the Scientific and Educational Exhibit

1958 Annual Meeting • Ohio State Medical Association

NETHERLAND HILTON HOTEL, CINCINNATI, APRIL 15, 16, 17

Fill Out and Mail to:

Committee on Scientific and Educational Exhibits,
Ohio State Medical Association,
79 East State Street,
Columbus 15, Ohio

DEADLINE FOR APPLICATIONS . . FEBRUARY 15, 1958

1. Title of Exhibit: .....
2. Name(s) of Exhibitor(s): .....

   Institution (if desired): .....

   City .....
3. Description of Exhibit: .....
   (Attach 200 Word Description to this Blank)
4. Exhibit will consist of the following: **(Check Which)**

   Charts and Posters..... Photographs..... Drawings..... X-Rays.....

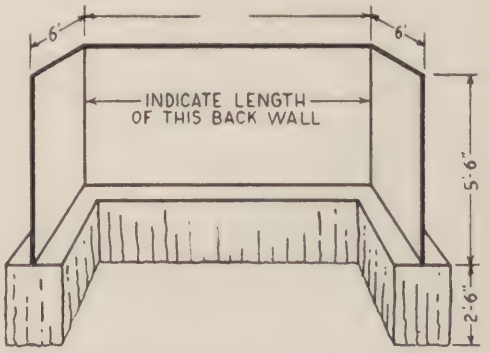
   Specimens..... Moulages..... Other Material .....
5. Booth Requirements:

   Length of back wall desired .....

   Minimum requirement .....

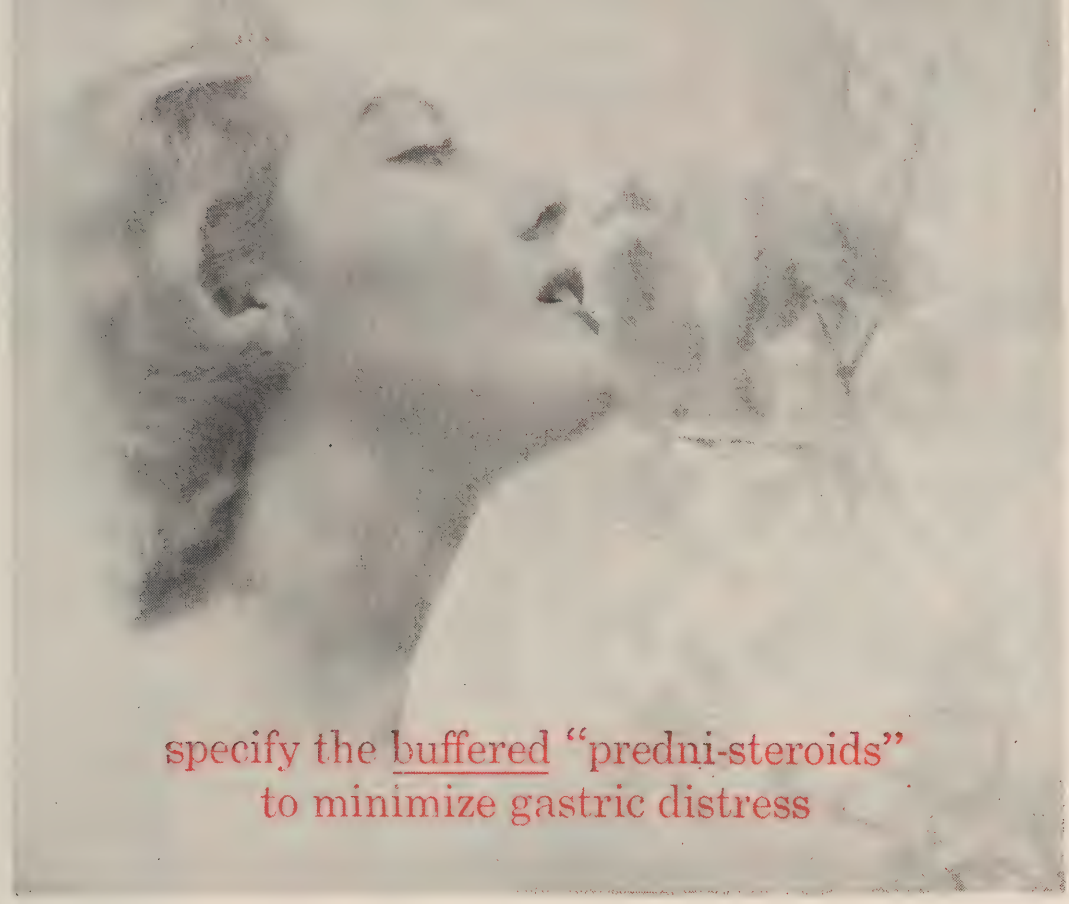
   Shelf desired (yes or no) .....

Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.



6. Do you want Association to provide view box..... or will you provide your own?..... OSMA will provide standard units; large size, 60 inches by 56 inches (inside measurements, 57 by 54); small size, 24 inches by 56 inches (inside measurements. 21 by 54). It is suggested that transparencies used should be no larger than 10 by 12 inches. All films should be in suitable mounts.

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to minimize gastric distress

combined steroid-antacid therapy . . .

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(Prednisone buffered)

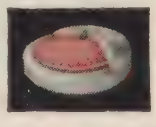
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BROADWAY HOTEL, Fourth & Broadway	$ 4.50- 7.00	$ 7.00- 9.50	$10.00-15.00
METROPOLE HOTEL, 609 WALNUT ST.	$ 5.50- 8.50	$ 8.50-12.00	$ 9.50-15.00
SHERATON-GIBSON HOTEL, 42 Walnut St.	$ 5.85-13.00	$ 9.85-16.00	$11.00-17.50
SINTON HOTEL, Fourth & Vine Sts.	$ 6.00-11.50	$ 9.00-13.50	$11.50-14.50
TERRACE HILTON HOTEL, 15 West 6th St.	$12.00-18.00		$16.00-22.00

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initiation of diuresis—prolonged maintenance[2] of diuresis

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smoothes out blood pressure fluctuations[1,2]

'DIURIL', added to the regimen is often effective in controlling the blood pressure of even highly resistant cases of hypertension

For smooth, sustained antihypertensive effect, the majority of hypertensive patients can be controlled better when 'DIURIL' is combined with significantly reduced amounts of antihypertensive agents

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Supplied: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide), bottles of 100 and 1000.

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1. Hollander, William, and Wilkins, Robert W.: Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension, Boston Medical Quarterly *8*:69 (Sept.) 1957.
2. Freis, Edward D., and Wilson, Ilse M.: Potentiating Effect of Chlorothiazide (DIURIL) in Combination with Antihypertensive Agents, a Preliminary Report; Med. Annals of the District of Columbia *26*:468 (Sept.) 1957.

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REFERENCES:

1. Moyer, J.H., Ford, R.V., and Spurr, C.L.: Pharmacodynamics of Chlorothiazide (Diuril), An Orally Effective Non-Mercurial Diuretic Agent, Proc. Soc. Exper. Biol. and Med. *95*:529 (July) 1957.

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AMA Philadelphia Meeting . . .

Important Actions Taken by House Include Statement on Free Choice Of Physician; Endorsing of Fluoridation; Opposition to Forand Bill

FREE choice of physician, the Heller Report on organization of the American Medical Association, the Forand Bill providing hospital and surgical benefits for Social Security beneficiaries, fluoridation of public water supplies, guides for occupational health programs covering hospital employees, distribution of Asian Influenza vaccine and guides for the medical rating of physical impairment were among the many subjects considered and acted upon by the House of Delegates at the American Medical Association's Eleventh Clinical Meeting, December 3-6, in Philadelphia.

OHIO DELEGATES ACTIVE

Ohio delegates who took an active part in the meeting were: Drs. Paul A. Davis, Akron; Fred W. Dixon, Cleveland; Charles L. Hudson, Cleveland; Carl A. Lincke, Carrollton; Carll S. Mundy, Toledo; L. Howard Schriver, Cincinnati; Clifford C. Sherburne, Columbus; and George A. Woodhouse, Pleasant Hill. The following Ohioans were delegates from their sections: Dr. Charles L. Leedham, Cleveland, Military Medicine, and Dr. Walter J. Zeiter, Cleveland, Physical Medicine.

Reference committee assignments of Ohio delegates included Committee on Executive Session, Dr. Schriver; Legislative and Public Relations, Dr. Davis; Miscellaneous Business, Dr. Lincke; and Sections and Section Work, Dr. Leedham.

Also attending the session were: Dr. Robert S. Martin, Zanesville, President of the Ohio State Medical Association; Dr. Richard L. Meiling, Columbus, Past-President; and Dr. Paul F. Orr, Perrysburg, Fourth District Councilor, each an alternate delegate; Dr. H. T. Pease, Wadsworth, Eleventh District Councilor; Mr. Hart F. Page, Assistant Director of Public Relations; and Mr. Charles E. Edgar, Jr., Administrative Assistant, of the State Association.

FREE CHOICE OF PHYSICIAN

Acting on the issue of free choice in relation to contract practice, the House passed a resolution which reaffirmed approval of previous interpretations of the Principles of Medical Ethics by the Association's Judicial Council and directed that they be called to the attention of all constituent associations and component societies. One Council opinion, issued in 1927 and reaffirmed in Philadelphia, stated that the contract practice of medicine would be determined to be unethical if "a reasonable degree of free choice of physician is denied those cared for in a community where other competent physicians are readily available."

The resolution also cited a Council opinion, published in the October 19, 1957, issue of *The Journal of the AMA*, which stated that the basic ethical concepts in both the 1955 and 1957 editions of the Principles of Medical Ethics are identical in spite of changes in format and wording. This opinion added that "no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 principles."

The 1927 Council report also pointed out that "there are many conditions under which contract practice is not only legitimate and ethical, but in fact the only way in which competent medical service can be provided." Judgement of whether or not a contract is ethical, the report said, must be based on the form and terms of the contract as well as the circumstances under which it is made.

REFER TO UMW PROGRAM

In another action related to the issue of free choice, the House adopted a resolution condemning the current attitude and method of operation of the United Mine Workers of America Welfare and Retirement Fund "as tending to lower the quality and availability of medical and hospital care to its beneficiaries."

The resolution also called for a broad educational program to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the "Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund" which were adopted by the House last June.

THE HELLER REPORT

Acting on the report of the Committee to Study the Heller Report on Organization of the American Medical Association, the House reached the following decisions on ten specific recommendations:

1. The office of Vice-President will be continued as an elective office.

2. The offices of Secretary and Treasurer will be combined into one office to be known as Secretary-Treasurer, and that officer will be selected by the Board of Trustees from one of its number.

3. The duties of the Secretary-Treasurer will

be separated from those of the Executive Vice-President.

4. The office of General Manager will be discontinued, and the new office of Executive Vice-President will be established. The latter, appointed by the Board of Trustees, will be the chief staff executive of the Association.

5. The Council on Medical Education and Hospitals and the Council on Medical Service will continue as standing committees of the House of Delegates, but their administrative direction will be vested in the Executive Vice-President.

6. The voting members of the Board of Trustees will be limited to eleven—the nine elected Trustees, the President and the President-Elect. The Vice-President and the Speaker of the House of Delegates will attend all Board meetings, including executive sessions, with the right of discussion but without the right to vote.

7. The House disapproved of the proposal to elect the Trustees from each of nine physician-population regions.

8. The office of Assistant Secretary will be discontinued, and a new office of Assistant Executive Vice-President will be established.

9. The Committee on Federal Medical Services will be retained as a committee of the Council on Medical Service and will not become a part of the Council on National Defense.

10. The Speaker of the House will appoint a joint and continuing committee of six members, three from the Board of Trustees and three from the House, to redefine the central concept of AMA objectives and basic programs, consider the placing of greater emphasis on scientific activities, take the lead in creating more cohesion among national medical societies and study socio-economic problems.

The accepted recommendations were referred to the Council on Constitution and Bylaws with a request to draft appropriate amendments for consideration by the House at the 1958 annual meeting in San Francisco.

THE FORAND BILL

Speaking at the opening session, Dr. David B. Allman of Atlantic City, AMA President, called for "more freedom, not less, in America and in the medical profession." Dr. Allman urged the delegates to embark on local action campaigns to enlist full community support in opposition to the Forand Bill, a pending Congressional proposal which would provide hospital and surgical benefits for persons who are receiving or are eligible for Social Security retirement and survivorship payments. The Forand Bill, he said, is "cut from the same cloth" as national compulsory health insurance and "emanates from the same minds."

The House condemned the Forand Bill as undesirable legislation, approved the firm position taken in opposition to it and expressed satisfaction that the Board of Trustees has appointed a special task force which is taking action to defeat the bill. In a related action, giving strong approval to Dr. Allman's address at the opening session, the House adopted a statement which said:

"It is particularly timely that our President has so forcefully sounded the clarion call to the entire profession for emergency action. With complete unity, definition and singleness of purpose, closing of ranks with all age groups and elements of our organization we must at this time stand and be counted. Thus we can exert the physician's influence in every possible direction against invasion of our basic American liberties in the form of proposed legislation alleged to compulsorily insure one segment of the population against health hazards at the expense of all."

FLUORIDATION OF WATER

The House of Delegates approved a joint report of the Council on Drugs and the Council on Foods and Nutrition which endorsed the fluoridation of public water supplies as a safe and practical method of reducing the incidence of dental caries during childhood. The 27-page report on the study which was directed by the House at the Seattle Clinical Meeting one year ago contained these conclusions:

"1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1 ppm of fluorine in drinking water has been established as a method for reducing dental caries in children up to 10 years of age. In localities with warm climates, or where for other reasons the ingestion of water or other sources of considerable fluorine content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least 44 years of age.

"2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1 ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries-inhibiting effect of the fluoride.

"3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of 1 ppm of fluorine."

INFLUENZA VACCINE

The House considered three resolutions dealing with the Asian influenza immunization program and then adopted a substitute resolution calling attention to "certain inadequacies and confusions

in the distribution of vaccines" and directing the Board of Trustees to seek conferences through existing committees "with a view to establishing a code of practices regulating the future distribution of important therapeutic products, so that the best interest of all the people may be served." The resolution pointed out that the American Medical Association already has a joint committee with the American Pharmaceutical Association and the National Association of Retail Druggists, in addition to a liaison committee with the Drug Manufacturers Association.

MEDICAL RATING OF PHYSICAL IMPAIRMENT

The House accepted a 115-page "Guide to the Evaluation of Permanent Impairment of the Extremities and Back" which was developed by the Committee on Medical Rating of Physical Impairment as the first in a projected series of guides. The guides are expected to be of particular help to physicians in determining impairment under the new disability benefits program of the Social Security Act.

HEALTH PROGRAMS FOR HOSPITAL EMPLOYEES

A set of "Guiding Principles for an Occupational Health Program in a Hospital Employee Group" was approved by the House. The guides were developed by a joint committee of the American Medical Association and the American Hospital Association and already had been formally approved by the A. H. A. They include these statements:

"Employees in hospitals are entitled to the same benefits in health maintenance and protection as are industrial employees. Therefore, programs of health services in hospitals should use the techniques of preventive medicine which have been found by experience in industry to approach constructively the health requirements of employees.

"It is essential that employee health programs in hospitals, as in industry, be established as separate functions with independent facilities and personnel. The fact that hospitals are engaged in the care of the sick as their primary function does not alter the necessary organizational plan for an effective occupational health program."

DR. MURRAY HONORED

Rear Admiral B. W. Hogan, Surgeon General of the U. S. Navy, presented the Navy Meritorious Public Service Citation to Dr. Dwight H. Murray of Napa, Calif., immediate past-president of the Association.

AMEF CONTRIBUTIONS

Contributions to the American Medical Education Foundation, for financial aid to the nation's medical schools, were presented by four state medical societies: California, $143,043.25; Utah, $10,390; New Jersey, $10,000, and Arizona, $8,040. The Interstate Post Graduate Medical Association of North America gave $1,000, and the Illinois State Medical Society announced that it was adding $10,000 to the $170,450 presented at the New York meeting last June.

NATIONAL GP OF THE YEAR

Dr. Cecil W. Clark of Cameron, Louisiana, was named 1957 General Practitioner of the Year after his selection by a special committee of the Board of Trustees for outstanding community service. Dr. Clark, 33-year-old country doctor who was a medical hero during Hurricane Audrey last June, was present at the meeting to receive the gold medal which goes with the annual award.

MISCELLANEOUS ACTIONS

Among a wide variety of other actions, the House also:

Directed that a new committee be established in the Council on Industrial Health to study **neurological disorders in industry**;

Noted with approval the establishment of the American Medical Research Foundation, which will initiate and encourage necessary **medical research** and correlate and disseminate the results of studies already under way;

Decided that informational materials which are sent to AMA delegates should also be sent to all **alternate delegates**;

Affirmed that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other **lawful groups** provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians;

Instructed that the appropriate committee or council should engage in conferences with **third parties** to develop general principles and policies which may be applied to the relationship between third parties and members of the medical professsion;

Urged state medical society committees on aging and insurance to make continuing studies of **pre-retirement financing of health insurance** for retired persons;

Asked the Board of Trustees to study the feasibility of having the Association finance a thorough investigation of the **Social Security** system by a qualified private agency;

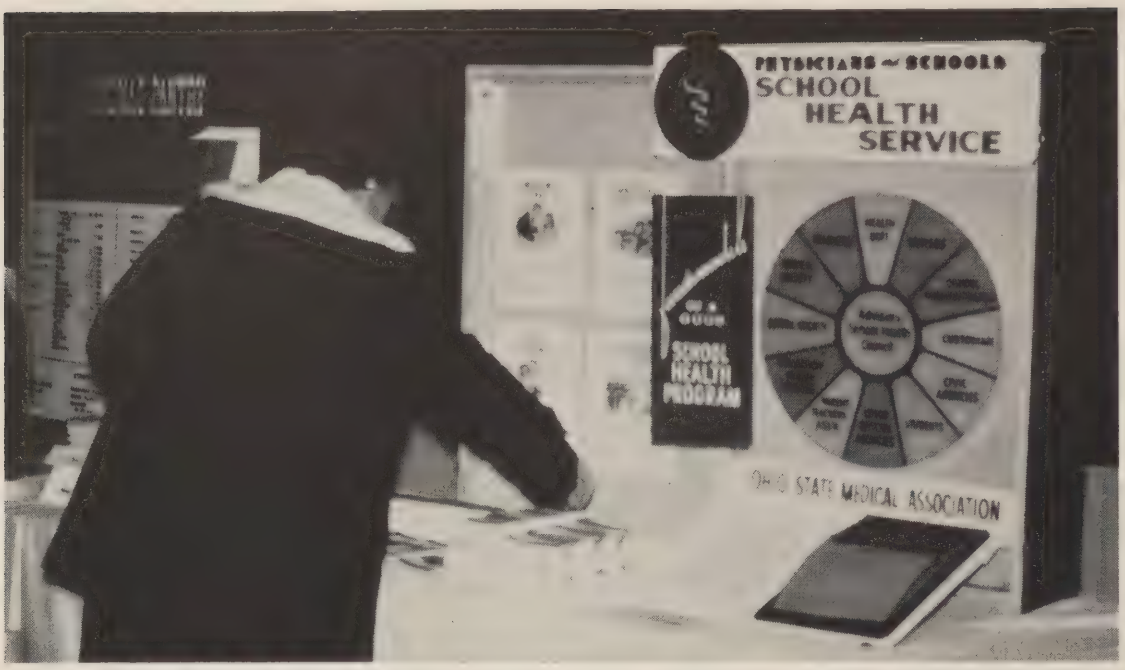
Suggested that physicians and their friends make a vigorous effort to obtain Congressional enactment of the **Jenkins-Keogh Bills**:

Approved "Suggested Guides to Relationships Between Medical Societies and **Voluntary Health Agencies**";

Strongly recommended that a completely adequate and competent medical department be established in the **Civil Aeronautics Administration** directly responsible to the CAA Administrator, and

Congratulated the General Electric Company for its medical television presentations on the subject of **quackery**.

Parent-Teacher Group Views OSMA Exhibit



This school health exhibit, along with appropriate literature, was displayed by the OSMA Committee on School Health at the annual meeting of the Ohio Congress of Parents and Teachers in Cleveland October 28 to 30. The exhibit was on loan from the American Medical Association.

Policy of Periodic Health Appraisal Gains Interest at Ohio Congress Of Parent-Teachers

Considerable interest in the new Parent-Teachers Association policy of periodic health appraisal for children from birth through high school was displayed by members of the Ohio Congress of Parents and Teachers who visited the Ohio State Medical Association's exhibit at the Congress' annual meeting in Cleveland October 28 to 30.

The periodic health appraisal calls for regular examinations of children, preferably in the office of the family physician and dentist.

The exhibit and appropriate accompanying literature were made available for the meeting through the efforts and interest of the OSMA Committee on School Health. State PTA members indicated extensive interest not only in the new school policy but in health records and other literature distributed from the exhibit.

This distribution included "Pre-School Health," (reprinted from *OSMJ*, January, 1957, page 90); "School Health Is a Community Undertaking," (reprinted from an article by Dr. Thomas E. Shaffer in the May, 1957 issue of *OSMJ*, page 541); the AMA Family Health Record and Personal Health Information Card, the OSMA School Health Guides and ABC's of a School Health Program, and the AMA's "What Everyone Should Know about Doctors."

One of the accomplishments of having the exhibit at the meeting was the opportunity to reiterate to the parents and teachers OSMA members' support of the periodic health appraisal in substitute of the old "one shot" preschool roundup.

Arrangements to point up the program and OSMA school health activities during the meeting were made as the result of a letter from Dr. Henry F. Helmholz, Chicago, national chairman of the National Congress of Parents and Teachers Committee on Health, to Dr. Thomas E. Shaffer, Columbus, chairman of the OSMA Committee on School Health.

Dr. Helmholz urged cooperation between medical and PTA organizations in promoting the new health policy. Dr. Shaffer immediately wrote Mrs. Gladys Davis, Medina, then the Ohio Congress president, offering the cooperation of his committee. This resulted in an invitation to participate in the Cleveland meeting. Cooperating with OSMA in exhibit arrangements were Mrs. D. S. Webster, Ashland, Ohio Congress health services chairman, and Mrs. John Cox, Seville, State PTA summer roundup chairman.

Manning the OSMA exhibit were Hart F. Page, secretary of the Committee on School Health, and Charles W. Edgar, administrative assistant, OSMA.

Forand Bill Opposed . . .

Council of OSMA Issues Special Statement Pointing Out Why Proposed Federal Medical and Hospital Plan Is Not in the Public's Interest

AT a meeting of The Council of the Ohio State Medical Association, December 15, 1957, in Columbus, The Council considered the provisions of HR 9467, introduced August 27, 1956, in the United States House of Representatives, by Rep. Aime Forand of Rhode Island, and subsequently referred to the House Ways and Means Committee. The bill would increase Social Security deductions to provide free hospital, nursing and surgical care for all persons eligible for retirement under OASI, regardless of their need or whether or not they had retired.

NOT IN PUBLIC INTEREST

It was the unanimous opinion of The Council that the passage of this bill would NOT be in the best interest of the public for the following reasons:

1. This proposal is another attempt to substitute government responsibility for individual responsibility.

2. The harassed American taxpayer is looking for tax reductions, not tax increases; pay increases, not more payroll deductions.

3. The proposed system of compulsory health insurance would be another step in the socialization of medicine, and could lead to the complete governmental control of the practice of medicine by extension of its provisions to all age groups.

4. The Forand Bill does not guarantee free choice of physician and hospital. It stipulates that beneficiaries would be restricted in their treatment to those individuals or institutions willing to enter into contracts with the government under its terms and conditions.

5. It would be unwise to provide additional benefits of unpredictable cost to the present over-taxed Social Security system.

6. The establishment of a system of governmental social security hospital and surgical benefits would jeopardize the future of voluntary insurance programs which have made such progress in recent years.

ACTION URGED

Believing that the Federal government already has gone too far in controlling the lives of its citizens through a paternalistic approach to the solution of problems which can be resolved through individual initiative, The Council strongly urges militant public opposition to this latest attempt to foist socialism on the American people through the passage of the Forand Bill.

Legislative chairmen of all county medical societies in Ohio have been advised of this action by The Council and urged to request their respective members of Congress to oppose the Forand bill should it come to a vote, and to ask all physicians in their counties to take similar action.

PROVISIONS OF PROPOSAL

The Forand bill would provide a maximum of 60 days of hospitalization in any year in semi-private accommodations, and for nursing home care for an additional 60 days, for a combined total of 120 days in any twelve-month period. Financed also would be the cost of any necessary surgery. The recipient could choose his own surgeon provided that he is certified by the American Board of Surgery or is a member of the American College of Surgeons. Necessary minor surgery, or surgery in case of emergency, would be permitted in a doctor's office; and in case of an emergency the doctor would not have to be a member of the Board of Surgery or the College of Surgeons. Physicians would be paid for their services in such amounts as prescribed by the Secretary of Health, Education and Welfare.

Hospital care could be received only in those hospitals which had entered into an agreement with the government. Eligible nursing homes would be only those homes where skilled nursing care could be obtained and which were operated in connection with a hospital, or in which services are under the direction of licensed physicians.

The persons eligible to receive this hospital and surgical care under the Forand bill would be all persons eligible to receive Old Age and Survivors benefits, including those persons who are retired and those persons who would be eligible to receive payments if they chose to retire. Survivors and dependents would also be eligible for this care. It is estimated that at present there are approximately 12 to 13 million persons in these categories.

Although it is difficult to ascertain the total cost of this proposed amendment to the Social Security Act, it has been estimated that it may run as high as $2,000,000,000 annually. In order to provide the additional funds, the Forand bill provides for an additional ½ per cent payroll tax on both employees and their employers. Self-employed persons would pay an additional ¾ of 1 per cent tax. The bill would also raise the amount on which the Social Security tax is computed from $4,200 to $6,000. Thus by 1975 employees and employers would be paying a payroll tax of 4¾ per cent each, for a total of 9½ per cent of an employee's wages. By that time self-employed persons would be paying 7⅛ per cent on the first $6,000 of their earnings. This would equal $427.50 annually.

Statement of The Council Of the Ohio State Medical Association

Regarding the Determination of the Ethical Status of Physicians Participating in Third-Party Medical Care Plans

An important statement of policy regarding the ethical status of members of the Ohio State Medical Association participating in third-party medical care plans was adopted by The Council of the Association at a meeting in Columbus on December 15, 1957.

The statement is intended as a guide to individual members of the Association and to the component county medical societies.

Copies of the statement have been sent to the president and secretary of each component county medical society of the Association and to members of each component county medical society in the Seventh Council District inasmuch as members and societies in that area of the state had presented the question to The Council for consideration and action.

The statement in its entirety reads as follows:

* * *

The Council of the Ohio State Medical Association has been requested to express an opinion with respect to the ethical status of physicians participating in a medical care plan the administrative and financial control of which is lodged in a third party. This question of ethical conduct grows out of recent changes in the administrative policy of the United Mine Workers of America Welfare and Retirement Fund, which have the effect of limiting the number of physicians and hospitals in a community that may participate in the Fund's third-party medical care program.

This Statement of The Council of the Ohio State Medical Association has been prepared after a careful study of reports, data, and recommendations furnished to The Council by a special committee of Councilors appointed by President Martin for this particular purpose.

At the very outset it should be pointed out that, in the opinion of The Council, a proper consideration of the ethical aspects of the participation by a physician in a medical care plan controlled by a third party requires a clear understanding of the announced policy of the medical profession with respect generally to contract practice, and particularly to third-party control of medical care plans. We shall therefore first examine and review the pronouncements of the AMA and of this Association on this subject.

CONTRACT PRACTICE AND THIRD-PARTY CONTROL OF MEDICAL CARE PLANS

The 1957 Principles of Medical Ethics contain no definition of "contract practice" and make no express reference to such term. However, the Judicial Council of the AMA has expressed the opinion that Section 6 of the 1957 Principles embraces the spirit and intent of Chapter VII, Section 3 of the 1955 edition of the Principles of Medical Ethics relating to contract practice. It is, therefore, pertinent to examine the provisions of Chapter VII, Sections 3 of the 1955 Principles; Section 3 reads as follows:

> "Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.
>
> "Contract practice per se is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered."

Moreover, the Judicial Council of the AMA has declared:

> "All medical practice is contract practice either implied or expressed between the physician and the patient if the patient be of legal age, or between the physician and the parent or guardian of a minor. There is no reason in law or morals why a physician should not enter into a contract with an individual, firm or corporation, provided that the contract be an honorable one for the performance of any

honorable act and not interfering with the rights of others."

In an opinion pertaining to contract practice the Judicial Council of the AMA in 1927 declared:

"* * * contract practice per se is not an ethical question, ethics being concerned with the form of the contract and the conditions under which it is made. That there are many conditions under which contract practice is not only legal and ethical but in fact the only way in which competent medical service can be provided becomes evident on analysis. * * * It is perfectly evident, therefore, **if we are to judge whether a contract is ethical or not, that we must know the form and terms of the contract as well as the particular circumstances under which it is made.** As there is such a great variety of contracts, as their form and the circumstances under which they are made differ so widely, it seems impossible, or at least inadvisable, to attempt to define what constitutes an ethical contract. **Each case must be judged on its own merits after all the facts pertaining thereto are known.** There are certain points, however, that may be formulated which, when present, definitely determine a contract to be unfair or unethical. These may be stated as follows:

"1. When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.

"2. When the compensation is so low as to make it impossible for competent service to be rendered.

"3. When there is underbidding by physicians in order to secure the contract.

"4. When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

"5. When there is solicitation of patients directly or indirectly."

Chapter VII, Section 5 of the 1955 edition of the Principles of Medical Ethics (the spirit and intent of which are embraced within Section 6 of the 1957 edition, according to the opinion of the Judicial Council of the AMA) also proscribe certain contract practices; Section 5 reads as follows:

"A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

At the regular annual session of the AMA House of Delegates in Cleveland in 1934, that body adopted a statement of policy containing ten basic principles to guide the profession in dealing with "social experiments." Certain principles of this ten-point statement are definitely applicable at this time to the relationship between the profession and third-party medical care plans, for example:

"All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

"No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

"Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

"Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established."

Editoralizing on the ten-point statement, the House of Delegates Reference Committee which had recommended approval of the statement, said:

"All these principles are directed toward protecting the character of the service to be given and all are directly designed to guard against abuses which experience shows are bound to arise when these principles are neglected. . . . That type of medical practice which preserves the personal relationships between physician and patient, that maintains the practice of medicine as a profession, and that has withstood the test of centuries must be preserved for the best interests of both the public and the medical profession."

An even more specific application of the traditional, basic tenets of the medical profession was made by the House of Delegates of the AMA in June of 1957 when it adopted "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund." While these guides refer to one particular third-party medical care program they are equally applicable to other third-party medical care programs. Under the heading "General Guides" the following fundamental concepts are listed:

"1. All persons, including the beneficiaries of a third party medical program such as the UMWA Fund should have available to them good medical care and should be free to select

their own physicians from among those willing and able to render such service.

"2. Free choice of physician and hospital by the patient should be preserved:

"a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.

"b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the quality of medical care, and avoid the exploitation of his services for financial profit.

"c. The medical profession does not concede to a third party such as UMWA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.

"3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.

"4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local hospital staffs and local governing boards of hospitals."

In 1930 when the subject of third-party medical care plans began to emerge as one of major importance to the medical profession, the Ohio State Medical Association expressed its views on fundamental and basic principles which must be observed by individual physicians if the medical profession as a whole is to retain professional freedom and be able to continue providing the public with high-quality medical service. At that time the House of Delegates of this Association declared:

"Any plan, system or activity which tends to destroy or lessen scientific research, individual initiative and ambition, adequate remuneration for effort and ability, scientific independence, reasonable competition, personal responsibility; which would lower the standards of medical education or inculcate unsound ideas in the public mind toward scientific medicine, are wrong, unwise, impractical and will inevitably be doubly costly to the public."

As recently as 1956, the House of Delegates of this Association adopted the following resolution:

"WHEREAS, Organized medicine wishes to retain its rightful place in American medical practice and to continue a system which has given the country its preeminent position in the medical world by taking a firm stand early on matters which encroach upon the rights, privileges and obligations of its members.

"THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as opposing:

"1. Gradually increasing restrictions on the acceptability of general practitioners for payment of fees from insurance or welfare funds.

"2. The issuance of over-all directives that seemingly condemn and often handicap all physicians because of the alleged misdeeds of a few.

"3. The use of economic or other types of pressure by any fund, insurance company or other agency to force patients to accept the services of any particular physician.

"4. Action by any agency qualifying or disqualifying a physician by standards other than merit and competence as judged by his colleagues, or certification by specialty boards or membership in professional societies.

"5. The use of economic pressure or coercion by local unions or any other agencies in attempting to secure hospital staff membership for physicians unacceptable to the hospital staff involved."

A careful reading of the policy statements quoted above leaves no doubt about the attitude of this Association and the AMA as to how third-party medical care plans should be operated in order to preserve those principles and standards of practice which are for the best interests of the medical profession and the public which it serves.

However, we must keep in mind the distinction between a mere policy declaration setting forth the views of this Association or of the AMA on the defects or deficiencies of third-party control of medical care plans and the promulgation of the Principles of Medical Ethics of the AMA. Such policy declaration does not create a new or different rule of conduct for any physician or group of physicians; it does not make unethical that which previously was ethical (or vice versa); a disregard by an individual physician, or by a group of physicians, of such policy declaration would not constitute necessarily or per se, a violation of the Principles of Medical Ethics.

On the other hand, the Principles of Medical Ethics are definite rules of conduct which have been promulgated by the AMA, and which every physician-member of the AMA, of this Association, and of any component medical society of this Association, has sworn to obey and uphold; **these Principles provide the tests by which the ethical or unethical conduct of a physician, or group of physicians, is to be determined; and a diseregard by any physician-member, or physician-members, of these Principles subjects him, or them, to disciplinary action.**

It follows, therefore, that **the question of whether or not a physician-member of this Association, or of a component medical society of this Association, is guilty of unethical conduct by rea-**

son of his participation in a third-party medical care plan can be determined only by the application of the Principles of Medical Ethics of the AMA and the interpretations thereof by the Judicial Council of the AMA. No new or different rule of conduct is necessary to this determination.

Twenty-five years ago, Dr. George Edw. Follansbee, then serving as Chairman of the Judicial Council of the AMA, observed that: "the principles of Medical Ethics are broad enough, and fundamental enough, to cover any situation that may arise warranting disciplinary measures. There is no real need for separate rules of conduct and their use only complicates, and sometimes defeats, an already difficult situation." The Council of this Association is in complete agreement with that statement of the former head of the Judicial Council.

APPLICABLE PROVISIONS OF PRINCIPLES OF MEDICAL ETHICS AND INTERPRETATIONS THEREOF

We pass now to a consideration of those sections of the current Principles of Medical Ethics which appear to be applicable to the question under discussion. These are Sections 5 and 6, and they read as follows:

> "**Section 5.** A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients."
>
> "**Section 6.** A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

In an official opinion the Judicial Council of the AMA has declared that Section 5 of the 1957 Principles of Medical Ethics embraces the spirit and intent of Chapter 1, Section 4, and Chapter II, Section 4, of the 1955 edition of the Principles, and that Section 6 of the 1957 Principles embraces the spirit and intent of Chapter VII, Sections 2, 3, 4, and 5 of the 1955 edition, and that no basic ethical principle set forth in the 1955 edition has been deleted, and that no traditional concept has been added or abrogated by the shorter 1957 version. This explanation is offered so that there will be no misunderstanding because of the fact that the discussion which follows makes reference occasionally to the more detailed sections of the 1955 edition of the Principles.

Chapter I, Section 4, of the 1955 edition reads, in part, as follows:

> "Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician."

Chapter II, Section 4, of the 1955 edition reads, in part, as follows:

> "A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, * * *"

The following are excerpts from Opinions and Reports of the Judicial Council which are applicable in the interpretation of Section 5:

> "It might be advisable at this time, when voluntary prepayment health insurance plans are progressing and when some plans are being offered by others, not connected with the medical profession, in which the formation of medical groups is being encouraged, to discuss the ethics involved in this situation. The Council would therefore remind members of the Association that while solicitation of probable insurers or insurees is necessary to the success of medical insurance plans and is permitted, **the solicitation of patients either by individuals or by medical groups is absolutely forbidden.** (1946 Report.)"
>
> "The Principles proscribe the solicitation of patients directly or indirectly. The House of Delegates of the Association has expressed disfavor with the practice of permitting one's name to be listed in a commercial advertising directory because it is or may be interpreted to be the indirect solicitation of patients. In 1936, a resolution was introduced in the House of Delegates. It reads as follows: 'Whereas, certain commercial interests are publishing medical directories, listing physicians by specialty and otherwise, as available for insurance and compensation work, and other professional services, and whereas, participating by listing these lay publications merely serves for the profit of the promoters and is furthermore more technically indirect solicitation of patients, be it Resolved that the Arkansas Medical Society condemns these practices as unethical and forbids its members to continue listing their names in such directories and be it further resolved that the Arkansas Medical Society requests the House of Delegates of the American Medical Association to take similar action.' The Reference Committee to which this resolution was presented reported that it 'is of the opinion that most, if not all, of the directories described in the resolutions, condemning as unethical the listing of physicians by specialty in directories published by commercial concerns, which were introduced by Dr.

Brooksher of Arkansas, are but subtle ways of avoiding the pronouncement of the Principles of Medical Ethics concerning solicitation of patients, under a guise of buying a directory when the real intent is the purchase of the publication of the buyer's name in the directory for the purpose of obtaining patients.' The Reference Committee report recommending approval of the resolutions was adopted by the House of Delegates.

"The Judicial Council quotes this action for emphasis and calls attention to the fact that the action of the House of Delegates is binding on the members of the Association. The Council would further state that a physician who uses or permits the use of his name in a commercial directory that fails to include on like terms and without discrimination the names of all licensed physicians practicing in the area served by the directory has the burden of proving that his action is in keeping with the Principles. (JAMA, June 9, 1956.)"

Chapter VII, Sections 2 and 4, of the 1955 edition of the Principles reads as follows:

"**Section 2.** A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care."

"**Section 4.** Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not per se cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability."

(Sections 3 and 5 of Chapter VII, also applicable here, are set out on pages 2 and 3 herein.)

The following are excerpts from Opinions and Reports of the Judicial Council, which are applicable in an interpretation of Section 6 of the 1957 edition of the Principles:

"The privilege of healing the sick as a profession is a right granted only to those properly qualified and licensed by the state. It is a privilege belonging only to the medical profession. It is a sacrifice of professional dignity that this exclusive right of medicine is so often sold for individual gain or its possessor deprived of it against his will. In increasing numbers, physicians are disposing of their professional attainments to lay organizations under terms which permit a direct profit from the fees or salaries paid for their services to accrue to the lay bodies employing them. Such a procedure is absolutely destructive of that personal responsibility and relationship which is essential to the best interests of the patient." (1932 Report)

"(a) The Judicial Council calls attention to the third point of the Ten Principles adopted in Cleveland in 1934 which defines 'free choice of physician.' This The Council interprets to mean not only the patient's right to choose any physician desired but also, conversely, the physician's right to accept or reject any patient requesting his services under the plan. It also expressly requires that any qualified, licensed physician residing in the area in which the plan operates be allowed to participate. * * *" (1947 Report)

In connection with the interpretation of Section 6 of the 1957 edition of the Principles, The Council of the Ohio State Medical Association again calls attention to the opinions, declarations, and resolutions discussed on pages 1 to 8 herein, under the heading: "Contract Practice and Third-Party Control of Medical Care Plans."

INITIAL DETERMINATION OF QUESTION OF ETHICAL CONDUCT IS RESPONSIBILITY OF COMPONENT MEDICAL SOCIETY

The determination of whether a physician-member of a component medical society of this Association is guilty of unethical conduct—whether in connection with his participation in a third-party medical care plan or otherwise—is, in the opinion of this Council, the responsibility primarily of the component society. The By-Laws of each component medical society affiliated with this Association, and the By-Laws of this Association, make ample provision for disciplinary action by the component society against any of its members who may be charged with the violation of any of the provisions of the Principles of Medical Ethics, and also make ample provision for the censure, and the suspension or expulsion from the society, of any of its members who may be found guilty of any such violation. **Our opinion in this respect is concurred in by the AMA, the Judicial Council having expressed the opinion that: "The remedy for the evils associated with contract practice resides in the County Societies."**

CONCLUSIONS AND RECOMMENDATIONS

After a very careful review and consideration of the foregoing pronouncements of the American Medical Association and of this Association, The Council of the Ohio State Medical Association, for the guidance of individual members and of the component county medical societies, presents the following conclusions and recommendations with regard to the status of members of the Association participating in third-party medical care plans:

1. The Ohio State Medical Association condemns and opposes any medical care plan which requires participating physicians to violate the

Principles of Medical Ethics of the AMA in order for such physicians to comply with the rules and regulations governing such plan.

2. The voluntary participation by a physician-member of this Association, or of any component society of this Association in a third-party medical care plan under conditions and circumstances which require, or result in, practices that are proscribed by the Principles of Medical Ethics of the AMA, as interpreted by the Judicial Council of the AMA, subjects such physician-member to disciplinary action by such component medical society. More specifically, any conduct or action on the part of the physician in connection with his participation in the third-party medical care plan which involves the sale or disposal of the physician's services under terms or conditions which:

(a) Permit exploitation of his services for the financial profit of the third party;

(b) Tend to interfere with or impair the free and complete exercise of his judgment and skill;

(c) Tend to cause a deterioration of the quality of medical care in the community;

(d) Involve solicitation of patients by the physician, directly or indirectly, or involve his consent to, or acquiescence in, solicitation of patients by others for or on behalf of the physician; or

(e) Deny to the members of the community in which the physician practices a reasonable degree of free choice of a physician or physicians,

would constitute a violation of the principles of Medical Ethics and subject him to disciplinary action by such component medical society.

3. Sections 5 and 6 of the 1957 edition of the Principles of Medical Ethics of the AMA, as interpreted by the Judicial Council of the AMA, offer appropriate tests for the determination of the ethical or unethical conduct of a physician-member in connection with his participation in a third-party medical care plan.

4. The Principles of Medical Ethics of the American Medical Association are broad enough and fundamental enough to cover any situation which may arise warranting disciplinary action on the part of a component county medical society against a member participating in a third-party medical care plan under conditions and circumstances which cause him to engage in unethical practices.

5. As the Judicial Council of the American Medical Association once declared: "the remedy for the evils associated with contract practice resides in the county society" and "each case must be judged on its own merits after all the facts pertaining thereto are known."

6. The By-Laws of the component county medical societies affiliated with the Ohio State Medical Association, and the By-Laws of the Ohio State Medical Association itself, provide effective ways and means for disciplinary action against members guilty of violation of any of the provisions of the Principles of Medical Ethics of the American Medical Association. Any such disciplinary action as the facts may warrant should be initiated by component county medical societies in conformity with their By-Laws.

New Members of OSMA

The following are the names of the new members of Ohio State Medical Association since November 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

ALLEN COUNTY
Bartholomew, Lee E., Lima
Kemph, John P., Elida
Leech, Thomas R., Lima
Reed, Alexander C., Lima
Shelly, Howard M., Bluffton
Wright, Gene E., Lima

BUTLER COUNTY
Smythe, Lowell J., Middletown

CUYAHOGA COUNTY
Allen, Griffin M., Cleveland
Ambrozaitis, Kazys G., Cleveland
Carson, James E., Cleveland
Delgado, Gustavo, Cleveland
Kuzas, Adolph, Cleveland
Leverich, Edward B., Cleveland
Meaney, Thomas F., Cleveland
Oseasohn, Robert O., Cleveland
Pasterczyk, Arthur A., Cleveland
Rush, James L., Bay Village
Vertes, Victor, Cleveland
Wallace, David, Cleveland
Walton, Robert O., Cleveland
Zietak, Boleslaw D., Cleveland

HAMILTON COUNTY
Amann, Charles J., Cincinnati
Brown, George E., Cincinnati
Hillman, Donald W., Cincinnati
Jett, Frank Lee, Cincinnati
Kirschner, Jack R., Cincinnati
Martin, Lester W., Cincinnati
McCorkle, Marilyn Rousey, Cincinnati
Mendez, Fernando L., Cincinnati
Perry, Harold, Cincinnati
Rubenstein, Jack H., Cincinnati
Schneider, Edward M., Kentucky
Strasser, Edward S., Cincinnati
Werner, Ferdinard, Jr., Cincinnati

LORAIN COUNTY
Chorny, John, LaGrange

LUCAS COUNTY
Galevi, Osman, Toledo
Kolb, Boris, Toledo

MADISON COUNTY
Wolber, Paul G. H., London

MIAMI COUNTY
Swihart, Danny D., Troy

MONTGOMERY COUNTY
Erwin, William A., Dayton

SUMMIT COUNTY
Dalheim, Leroy, Akron
Ruoff, Frederick A., Akron

Obstetrics and Gynecology Board Examinations

The next scheduled examinations (Part II), American Board of Obstetrics and Gynecology, oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 7 through 17, 1958. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates, reported Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, secretary of the board.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Medical School Enrollment . . .

With 7,791 Freshman Medical Students During Past Session, Total Enrollment Continues To Increase, Report of AMA Committee Shows

OF every 100,000 persons in the United States, 4.7 were enrolled as freshmen in American medical schools during 1956-57. In fact, there were more freshmen medical students that year than ever before: 7,791, compared with 7,686 in 1955-56, according to the 57th annual report on medical education made by the American Medical Association's council on medical education and hospitals.

However, the number of 1957 graduates (6,796) from 78 approved four-year schools was slightly smaller than the 6,845 graduated in 1956.

The 7,791 freshmen were part of 28,852 students enrolled in the 78 four-year approved medical schools and four schools of two-year basic medical science in the U. S. 1956-57 was the eighth consecutive year that a new record in total enrollment was established, the report said. In 1956-57 there were 28,639 students enrolled.

In addition to teaching these medical students, the schools also undertook to teach more than 62,000 other undergraduate students in allied medical fields. These were in dentistry, nursing, pharmacy, x-ray, and medical technology, arts and science courses, physical or occupational therapy, and medical records and medical librarianship. The schools also assisted in the education of interns and residents and practicing physicians doing postgraduate study.

The schools spent more than $200-million in 1956-57, the report said. The cost of supporting the many activities of medical schools has risen steadily with the expansion of those activities and with the general increase in the price of services and goods. Since so many of the schools' funds come directly or indirectly from public sources, there should be available a more meaningful method of accounting for expenditures, the report said.

In fact, an editorial in the November 16 *AMA Journal*, in which the report appears, called for the development of a uniform system of cost accounting among medical schools. In that way, schools could tell more exactly where their money goes and why they need the amounts they do.

SOURCES OF SUPPORT

Much financial support has been given to the schools by two organizations, the American Medical Education Foundation, which is supported by physicians and medical organizations, and the National Fund for Medical Education, which draws its funds from industry and the Ford Foundation. During 1956, 39,892 contributors gave the foundation $1,072,727, an increase of 40 per cent over 1955. The National Fund gave $3,066,450 to medical schools last January.

The report also showed the following:

During 1956-57 the schools of medicine at the University of Mississippi and the University of Missouri graduated their first classes. The University of Florida Medical School, Gainesville, Florida, and Seton Hall College of Medicine and Dentistry, Jersey City, N. J., enrolled their first classes.

Beginning in September 1960, the University of West Virginia will enroll third year medical students. At present it has only a two-year school of basic science. First classes will be admitted at the University of Kentucky, Lexington, in 1959 or 1960.

Thirty-three schools reported initiation or completion of major construction projects. Nineteen began projects estimated to cost about $32,200,000, while 20 completed projects representing an investment of $67,500,000.

There were 1,646 women enrolled in medical schools during the year, and 330 women were graduated in 1957.

Ninety American citizens were enrolled in the 12 Canadian medical schools, while eight Canadians were in U. S. schools.

DISASTER MEDICINE

Forty-five American medical schools are now participating in a special program dealing with the problems of military and disaster medicine.

The program, Medical Education for National Defense (MEND), was started in 1952 with five pilot schools. It has steadily expanded and now includes more than 14,000 medical students in 45 schools.

The cost of the program has been most reasonable, averaging $10,000 per school per year, or about $30.00 per student. Last year the total cost including the operation of a coordinator's office in Washington was $325,000 for 35 schools.

The program is carried out in medical schools, under the supervision of the individual school in whatever manner the faculty sees fit. Annually MEND sponsors a series of symposiums at federal medical installations. It also conducts a tour for deans and coordinators of MEND-affiliated schools, designed to introduce them to current problems and trends in the federal services.

Activities in the medical schools include special lectures, conferences, and demonstrations in surgery of trauma, war wounds, radiobiology,

defense measures of chemical and biological warfare, aviation medicine, and various other medical civil defense problems.

MEND is a function of the MEND program subcommittee of the Association of American Medical Colleges. It is endorsed by the AMA's councils on national defense and medical education and hospitals, and by medical officials of the Department of Defense, Army, Navy, Air Force, Public Health Service, and Federal Civil Defense Administration.

Central Ohio Heart Group To Present Program in Columbus, January 22

Dr. Dwight E. Harken, Boston, will address the Scientific Council of the Central Ohio Heart Association, Wednesday, January 22. All Central Ohio physicians are invited to attend the all-day session, which will be held at Room M-100, Starling-Loving Hospital, Ohio State University.

Dr. Harken is an associate clinical professor of surgery, Harvard Medical School, and a surgeon at Peter Bent Brigham Hospital, Boston. He is also surgeon and chief of the Department of Thoracic Surgery, Mount Auburn Hospital, Cambridge, Mass., and Malden Hospital, Malden, Mass., and consultant in thoracic surgery at 12 Eastern hospitals.



DR. HARKEN

The meeting will open at 10 a. m. with a panel discussion of "The Evaluation of the Patient for Cardiovascular Surgery." Serving as panel moderator will be Dr. Joseph Ryan, University Hospital, Columbus. Panel members include Dr. Harken; Dr. Don Hosier, Children's Hospital, Columbus; Dr. Howard Sirak, University Hospital, and Dr. Hugh Hull, University Hospital. The panel discussion will evaluate not only the objective and subjective findings in the patient, but also arteriography, cardiac catheterization and function tests.

After a luncheon at the Jai Lai Restaurant, the group will meet again at 2 p. m. to hear Dr. Harken's address entitled "The Surgical Correction of Aortic Stenosis." From 3 to 4 p. m. a cardiac Clinical-Pathological Conference will be held.

Cincinnati Area GPs

The next meeting of the Southwestern Ohio Society of General Physicians will be on January 19 from noon to 4:30 p. m. at the Hartwell Country Club. The topic will be "Heart Disease."

At the meeting on November 24 a team from the University of Cincinnati College of Medicine, discussed the subject "Pathology of the Male Perineal Organs."

Mr. Stuart Named To Direct National Blue Cross Association

James E. Stuart, Cincinnati, since 1941 director of the Hospital Care Corporation, the Blue Cross Plan for Southwestern Ohio, has been named director of the newly reorganized Blue Cross Association, with headquarters in New York. He will continue his association with Hospital Care Corporation as a consultant.

Earl H. Kammer, recently named director of the Board of Trustees, will take over the duties and responsibilities of Mr. Stuart.

Speed-Up Payment Plan of BWC Appears To Be a Success

Prompt payment of physician's fees for medical-only Workmen's Compensation cases seems to be assured by the mechanized method of processing claims recently initiated by James L. Young, BWC Administrator.

At the request of *The Journal*, Mr. Young prepared the following progress report as of December 17, 1957:

"In October over 11,000 letters and return post cards were mailed to Ohio physicians requesting license numbers for use in coding a punch card system for rapid processing of medical only payments. Over 9,000 cards have been returned. Problems, such as number duplication, are being handled individually with the physicians involved. Clinics are being assigned special numbers if it is desired that the payment be made in that manner.

"The first nine days of operation were tabulated on December 10th. Twenty thousand, six hundred and seventy-one items were processed for payment with the following disbursements:

Hospitals	$ 71,341.52
Physicians	159,907.07
Clinics	26,376.74
Total	$257,625.33

"The checks to hospitals and clinics were mailed on December 11th. Checks to 2,687 physicians were mailed December 16th. These disbursements are all in addition to payments processed in the normal routine.

A second disbursement is being prepared for the end of December which will be larger. A third will probably be necessary in early January to bring medical-only payments to a current basis.

"As soon as it is administratively feasible, all medical payments will be included in the punch card system. The Bureau appreciates greatly the cooperation of Ohio's physicians in creating a successful system.

"The Bureau requests that each physician indicate his license number on each fee bill filed with the Bureau. It is suggested that it be incorporated in a stamp showing name and address to facilitate processing."

Facts and Policies About Annual Dues . . .

Amount of Dues; Date Due; Payable to Whom? Those Exempt From Payment; Data on AMA Dues and Exemptions; Getting Journals

HERE are some important facts and reminders regarding 1958 membership dues. It is vital for each physician to keep his membership in the State Association, his county Medical Society, and the AMA up to date. Those who have not paid 1958 dues should get in touch with their County Society secretary - treasurer immediately.

Amount of Dues: State Association, $25.00 or $7.50 in the case of interns and residents; AMA, $25.00; County Society, amount varies from county to county—See your local secretary-treasurer.

Membership and Dues for Residents and Interns: A physician serving a hospital internship or residency within a period of five years following graduation from the medical school (excluding time in military service), who becomes a member of a county medical society and meets the membership eligibility requirements of the OSMA By-Laws, **does not** have to pay full state dues for 1958. By official action of The Council September 14-15, 1957, state dues for such members were set for 1958 at $7.50. Such members will not receive *The Journal* automatically but may subscribe to *The Journal* at one-half the regular rate—namely for $2.50.

So far as AMA membership is concerned, the AMA By-Laws provide that it may excuse from the payment of AMA dues, interns and residents during the first five years following graduation from medical school (excepting military service) provided their local and state dues are fully or partially waived. Therefore, intern and resident members in Ohio who are assessed the partial dues ($7.50) will be entitled to AMA membership without payment of AMA dues. However, in order to receive the *AMA Journal* or some other AMA publication, they will have to purchase a regular subscription from the AMA.

Date Dues are Due: On or before January 1, 1958. Membership is on a calendar year basis.

Dues Payable to Whom?: Secretary-treasurer of County Medical Society. When paying dues to him, send check for total amount of local, State and AMA dues. Maintaining membership in the AMA is optional, but the large majority of Ohio physicians belong to the AMA. Don't send dues direct to Columbus Office—pay them to local secretary-treasurer.

Who is Exempt From State Dues? There are only two classes of members of the OSMA who are exempt from the payment of state dues, namely:

(a) **Military Members:** Members of the OSMA on extended active duty in the military service or U. S. Public Health Service but who are not making military medicine or public health work a career, are entitled **to exemption from OSMA membership dues** while they are in the service. Dues paid by a member before entering the service will not be refunded, but dues will be waived if he enters the service prior to paying dues. Certification from local secretaries will be necessary in all such cases.

(b) **Aged or Disabled Members:** A member **who retires,** or has been retired, from active practice because of **age or disability** and who was in good standing at the time of retirement is exempt from the payment of State dues, **providing he requests such exemption and such request is approved in writing by the secretary-treasurer of his county medical society.**

Remember: The determining factor is not how old the physician is but whether he has retired from active practice.

Who Is Exempt From AMA Dues?: The following physicians, who are members of the OSMA either through payment of OSMA dues or by exemption of OSMA dues, can carry membership in the AMA without paying AMA dues:

(a) **Military Members:** OSMA members in temporary military service prior to January 1, 1958, are entitled to AMA membership **without payment of dues.** Members entering military service prior to July 1, 1958, will owe AMA membership dues of $12.50—one-half year; those entering military service after July 1, 1958, will owe dues for the entire year—$25.00. Military members for whom AMA dues are waived and who desire to receive *The AMA Journal* while in the service may do so by buying, directly from the AMA, an annual subscription in the amount of $15.00. The *OSMA Journal* is sent to such members without charge.

(b) **Aged and Disabled Members:** OSMA members who are exempt from payment of OSMA dues because of retirement from active practice due to **age or disability** are entitled to AMA membership without payment of AMA dues. The names of such members will be certified automatically to the AMA annually by the Columbus Office after their names are entered on the OSMA roster as dues-exempt members for the current year.

(c) **Members 70 years of age:** Members of the OSMA, after attaining the age of 70 years, will be eligible for membership in the AMA

without paying AMA dues, **starting on January 1 following such member's 70th birthday, providing such member requests such exemption.** Such members should file their request for AMA exemption with the Columbus Office after they have received their OSMA membership card for 1958, or any subsequent current year. The Columbus Office will certify their names to the AMA. This AMA exemption will be automatic year by year, providing the physician's name is carried on the membership roster of the OSMA, either as a dues-paying member or as a retired member. To get the *AMA Journal* these 70-year old members must purchase a subscription.

(d) Members of the OSMA who are serving an internship or residency during the first five years following graduation from medical school (excluding time in military service). This is because their dues are partially waived by the OSMA (they pay only $7.50 to OSMA). Those in postgraduate training after the five-year period are not excluded from paying AMA dues.

Those not exempt from OSMA dues: The following are not exempt from the payment of OSMA dues, either $25.00 or $7.50:

(a) **Members in practice or in internship or residency training.** As mentioned previously, those in internship or residency during the first five years following graduation from medical school (excluding time in military service) are assessed dues of $7.50—not $25.00 the dues of other classes of paying members.

(b) **Regular commissioned medical officers of the Army, Navy, Air Force, or U. S. Public Health Service, and permanent medical officers of the Veterans Service and the Indian Service are NOT exempt from OSMA dues.** If they desire to be members of the OSMA, they must qualify the same as civilian physicians and pay current dues. However, physicians of these classes are eligible to apply for **Service Membership in the AMA,** and if accepted into Service Membership, will not be required to pay AMA dues.

Send Change of Address Promptly: Occasionally a new member wonders why he does not receive the OSMA and AMA journals at once. The answer is simple. It takes the OSMA Columbus Office about four weeks to get a new stencil made and the mailing list adjusted to take care of mailings to new members. It takes the AMA longer because of its very large mailing list. Also, some months extra copies of the journals are quickly exhausted. Moreover, the Post Office Department frequently causes the delay in delivery. The Columbus Office makes a real effort to send out OSMA journals to new members by special handling but that can't always be expedited. If a new member fails to get the magazine on two consecutive months, something is wrong and he should notify the Columbus Office. All members can help the Columbus Office in keeping the mailing list up to date by sending in changes of address promptly.

Journals: State Association members, who pay full dues or are exempt from payment of any dues, receive *The Ohio State Medical Journal* as a part of their membership privileges—no extra charge for *OSMA Journal.* Those who pay dues to AMA receive the *Journal of the AMA* as a part of their membership privileges—no extra charge for *AMA Journal.*

A dues-paying AMA member may secure in lieu of the *AMA Journal,* any other official publication of the AMA **on special request by him direct to the AMA** at 535 N. Dearborn Street, Chicago. These publications are: *Archives of Internal Medicine, American Journal of Diseases of Children, Archives of Dermatology and Syphilology, Archives of Neurology and Psychiatry, Archives of Pathology, Archives of Surgery, Archives of Otolaryngology, Archives of Ophthalmology,* and *Archives of Industrial Hygiene and Occupational Medicine.*

Those exempted from payment of AMA dues must place a special subscription for the *AMA Journal* direct to the AMA or any one of the other publications if they desire to receive such publication.

Do You Know? . . .

A total of 652 physicians attended the annual meeting of the Sixth Councilor District of the OSMA at Canton, October 23. Dr. Howard J. Ickes, Canton, was chairman for the meeting. The 1958 meeting will be held at Akron on October 22.

* * *

Hart F. Page, Assistant Director of Public Relations of the Ohio State Medical Association, has been named a member of the Board of Directors of the Ohio Trade Association Executives. He also just completed a one-year term as President of the Columbus Chapter, Public Relations Society of America, and was elected to represent that chapter on the Board of Directors of PRSA.

* * *

Ohio members of the U. S. Congress and members of the Ohio General Assembly received *Today's Health* with the compliments of the Ohio State Medical Association.

* * *

The Cincinnati Post devoted a full page in its magazine section of October 26 to an article about Dr. Louis E. Cook, a practicing physician in the Price Hill area of Cincinnati for 63 years and still active at the age of 86.

* * *

Medical societies interested in developing worthwhile local radio and television programs may secure copies of the summary of the recent radio-TV conference sponsored by the AMA and the National Association of Radio and Television Broadcasters from the AMA's Public Relations Department.

Students' Views on Economic Issues . . .

Survey Taken on Anticipated Fees, Types of Practice, Specialization And Other Important Future Issues, Published by Ciba Medical News

CARRYING the headline, "1,000 Students View Private Practice," this article containing some interesting material about the opinions and views of today's medical students appeared in a recent issue of *Medical News*, published by Ciba Pharmaceutical Products., Inc.:

* * *

Where do today's medical students stand on some of the economic issues bothering their elders in the profession? Salaried practice versus fee-for-service practice, for example, or individual versus group practice?

How much money do they expect to be earning ten—and twenty—years from now? What specialties do they prefer?

This article, based on a recent study by a research team of the National Opinion Research Center, University of Chicago, offers some up-to-date answers. The survey consisted of personal interviews with 1,086 male students in 44 medical schools during May and June of 1956. The findings have just been published by Don Cahalan and Patricia Collette, and Capt. Norman A. Hilmar of the Army Medical Service Corps. The research was supported by the Surgeon General's Office, Department of the Army.

PREFER FEE FOR SERVICE

Nine out of ten medical students prefer some type of private, fee-for-service practice to salaried practice in any form. Their reasons:

1. Fear of restrictions and limitations on their practice, if salaried.
2. Fear that the relationship between doctor and patient might be unsatisfactory.
3. Fear that the doctor would have little variety in the medical cases he would handle.
4. Fear that his chances for advancement would be determined by others.

These fears are directed, Mr. Cahalan and his colleagues reported, not only against salaried private practice, but also against salaried practice for some governmental agency or one of the Armed Forces.

In contrast, the students—and the survey cut across all four years of medical school—are sharply divided in their opinions about individual and group practice.

Only 26 per cent prefer completely independent practice; 31 per cent individual practice with pooling of some facilities with other doctors; and 30 per cent, group practice in a partnership arrangement.

Their reasons? Of those choosing solo practice, 79 per cent said, "I want to be my own boss." Of those in the second category, preferring individual practice with pooling of some facilities, 72 per cent cited efficiency and/or economy as the main reason.

Those plumping for group practice gave these reasons:

(1) More time for one's private life (62 per cent); (2) more opportunity for consultation (57 per cent); (3) greater efficiency and economy (31 per cent); (4) the intellectual stimulation of other doctors (22 per cent).

The student who gets into medical school apparently has few doubts that medicine is the career for him. The survey showed that only 1 per cent could think of any more satisfying career. Most of those interviewed gave idealistic reasons for choosing medicine, such as "helping others" or "working with people."

MEDIAN IS $22,340

But a surprising three out of ten specified financial return or economic security as one of the things they expect to like best about being a doctor. And when it came to anticipated incomes, almost all the students in the survey indicated they did not expect to be underpaid.

Senior students estimated their annual net income at $16,230 ten years out of medical school —about $2,000 more than did freshmen when they looked ahead 13 years. As a group they anticipated a net income of $22,340 (median figure) at the height of their career. Only 1 student in 100 predicted he'd be making less than $10,000 at his peak.

One startling finding: Seniors planning a career in general practice estimated their income after 10 years at $16,820—about $700 more than did those planning to specialize.

Those preferring to specialize, however, outnumbered those planning a general practice career by 3 to 1. All students were asked: "If you were to specialize in your practice, what field of specialization do you think you would prefer? What field do you think you would like the least?" The results:

	Preferred	Liked Least
Internal medicine	30%	1%
Surgery	22	11
Pediatrics	10	5
Obstetrics and gynecology	10	7
Psychiatry and/or neurology	8	13
Orthopedics	2	3
Pathology	2	11
Ophthalmology	1	4
Otolaryngology	—	5
Public health or preventive medicine	—	6
Other specialties	5	27
Can't decide	10	7

SEARLE *announces...*

a superior psychochemical
for the management of both
minor and major
emotional disturbances



Dartal

T. M.

dihydrochloride — brand of thiopropazate dihydrochloride

- more effective than most potent tranquilizers
- as well tolerated as the milder agents
- consistent in effects as few tranquilizers are

Dartal is a unique development of Searle Research, proved under everyday conditions of office practice

It is a single chemical substance, thoroughly tested and found particularly suited in the management of a wide range of conditions including psychotic, psychoneurotic and psychosomatic disturbances.

Dartal is useful whenever the physician wants to ameliorate psychic agitation, whether it is basic or secondary to a systemic condition.

In extensive clinical trial Dartal caused no dangerous toxic reactions. Drowsiness and dizziness were the principal side effects reported by non-psychotic patients, but in almost all instances these were mild and caused no problem.

Specifically, the usefulness of Dartal has been established in psychoneuroses with emotional hyperactivity, in diseases with strong psychic overtones such as ulcerative colitis, peptic ulcer and in certain frank and senile psychoses.

Usual Dosage • In psychoneuroses with anxiety and tension states *one 5 mg. tablet t.i.d.*

• In psychotic conditions *one 10 mg. tablet t.i.d.*

You and Your Public . . .

Public Relations Often Start with the Medical Assistant; She Should Be as Much a Part of the PR Team as She Is Part of the Medical Team

THE importance of the medical assistant as a member of the physician's office public relations "team" was aptly brought out in Columbus recently when 325 persons attended a PR institute for such personnel.

Emphasis was placed on the importance of the medical assistant not only as a member of the medical "team" but also on the manner in which the assistant's attitude reflected either good or bad public relations for the physician and the medical profession.

The occasion was the fifth annual Public Relations Institute for Medical Assistants, and it drew the largest attendance ever recorded at this annual event, sponsored by the Columbus Academy of Medicine. Included in the attendance were 220 medical assistants.

Stressing the PR role of the assistant was Leo E. Brown, director of public relations, American Medical Association. Mr. Brown pointed out that courtesy, kindness and consideration when dealing with patients is basically good human relations and helps the desired type of public relations.

KNOW THE ISSUES

He urged institute members not only to know the keys to good PR but also to become familiar with important issues facing the medical profession.

Institute observes emphasized that the lively interest the medical assistants displayed strongly indicated a desire on their part to know, understand and practice good public relations policies.

Columbus physicians served on discussion panels as a part of the institute, an indication to the medical assistants the importance their employers attach to the subject.

INDOCTRINATION COURSE

For the physician who is not able to send his office staff to such an institute, there is a "short course" with which he can indoctrinate them.

First, office personnel should be made aware that the physician has four "publics," namely, (1) his patients, (2) his colleagues, (3) community leaders who, by tradition, turn to a medical man for advice and help on many social and civic problems, and (4) his suppliers—the "detail men." To discuss the first "public":

The most important group is, of course, the patients. There are three types of patient contacts—in person, telephone and mail. The PR-minded person does not slight any of these contacts.

The office assistant should never leave the phone unattended. She should answer it promptly and identify the physician's office. Whether the caller is requesting an appointment or information, the request should be met courteously and promptly. However, care must be taken that information provided is not confidential or restricted.

As for the personnel contact, nothing leaves a patient colder than to be permitted to enter the office and find his own seat without as much as a greeting or word of welcome.

The receptionist, for example, should greet each patient individually. If the doctor is out or delayed, she should explain why courteously. Knowledge about the background and interests of a patient helps to add to the warmth of his welcome.

An extra effort to ease the anxiety of the patient who "waits in fear" pays PR dividends.

After the patient has seen the doctor, he should be informed of any future appointment and asked if he has any questions—an unhurried goodbye sends the patient on his way with a better feeling.

A polite inquiry about the bill—"Would you like to take care of the fee now or would you like to be billed later?"—often results in payment on the spot and eliminates mailing a statement later.

When billing by mail, don't try to get the bill to the patient's home before he gets there. By the same token, don't delay too long in billing, for then the doctor's service no longer is fresh in the patient's memory.

All patients should be informed of the doctor's policy on house calls and emergencies.

To sum it up, well-informed patients are understanding patients—a good PR asset.

Loans Available for Resident Studies in Chest Diseases

To stimulate interest in postgraduate study of chest diseases and to assist worthy postgraduate students in continuation of study in diseases of the chest, the American College of Chest Physicians has established a loan fund. Application may be made by any physician who has completed an internship and wishes to continue studies in chest diseases. Loans may be up to $1,000 per year with a limit of $3,000 to any one student. Details may be obtained from the College at 112 E. Chestnut St., Chicago, 11.

In Memoriam . . .

Matthew M. Applegate, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1909; aged 73; died November 15; member of the Ohio State Medical Association through 1950. Dr. Applegate had retired several years ago after practicing for many years in the Cincinnati area.

Leo C. Bean, M. D., Gallipolis; Johns Hopkins University School of Medicine, 1915; aged 68; died November 15; member of the Ohio State Medical Association, the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. An earlier resident of Gallipolis, where his father, the late Dr. Lewis Bean, practiced, Dr. Leo Bean returned there in 1919 after doing graduate studies in St. Louis. He was active in numerous community affairs, was a founder of the Gallipolis Clinic, and for a time was a trustee of the Holzer Hospital Foundation. He was a past-president of the Rotary Club, a member of the Elks Lodge and an elder in the Presbyterian Church. Survivors include his widow, two daughters, a sister, and a brother, Dr. Lewis A. Bean, now residing in Coca Beach, Fla.

Albert R. Burkhart, M. D., Woodsfield; Ohio State University College of Medicine, 1922; aged 61; died November 19; member of the Ohio State Medical Association and the American Medical Association; secretary of the Monroe County Medical Society. Dr. Burkhart practiced in the Woodsfield area for 30 years, having moved there after completing an internship in Cleveland. Surviving are his widow, three daughters, a son, three sisters and two brothers.

Harry M. Butler, M. D., Newark; University of Cincinnati College of Medicine, 1928; aged 55; died November 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Butler practiced for some 22 years in Newark, having moved there from Mt. Vernon in 1935. He was a member of several Masonic bodies, was a trustee in the Presbyterian Church and was active in other community organizations. Surviving are his widow, a daughter and a son, Dr. Harry M. Butler, who is now serving in the Medical Unit of the Marine Corps; also a brother and a sister.

William C. Clark, M. D., Cincinnati; University of Cincinnati College of Medicine, 1912; aged 73; died December 1; former member of the Ohio State Medical Association. A native of Covington, Ky., Dr. Clark practiced in the Cincinnati area from 1912 until his retirement about four years ago. He was a 50-year member of the Masonic Lodge. Survivors include his widow, a stepson and a sister.

Dominic P. Donisi, M. D., Cincinnati; Hahnemann Medical College and Hospital of Philadelphia, 1931; aged 55; died November 28; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Donisi practiced medicine in the Cincinnati area for 26 years. He was a member of the American Medical Relief for Italy Committee. Surviving are his widow, a daughter and two brothers.

Willard G. Drown, M. D., Warren; Ohio State University College of Medicine, 1923; aged 59; died December 9; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Drown had been a practicing physician in Warren since 1924. He was a veteran of both World Wars and during World War II served as major in the Army Medical Corps. Affiliations included memberships in the Elks Club, the Community Church and the Trumbull Country Club. Surviving are his widow, a son, his stepmother and a brother.

Thomas Ludlow Ferenbaugh, M. D., Columbus; Johns Hopkins University School of Medicine, 1909; aged 76; died December 5; an affiliate member of the Columbus Academy of Medicine and Fellow of the American College of Surgeons. Colonel Ferenbaugh retired in 1945 after serving 36 years with the Army Medical Corps. He was stationed at Fort Hayes in Columbus from 1930 to 1936 and during World War II served with the 37th Division. The Legion of Merit was awarded him in 1946. Colonel Ferenbaugh was past-president of the Retired Officers Club, a member of the American Legion, member of Psi Upsilon and Alpha Kappa Kappa and the Masonic Lodge. Surviving are his widow, a daughter and a half-sister.

Walter B. Johnson, M. D., Winter Park, Florida; Western Reserve University School of Medicine, 1931; aged 55; died November 19; former member of the Ohio State Medical Association. Dr. Johnson practiced from 1933 to 1945 in Lakewood. During World War II he went into service and held the rank of Colonel in the Army Medical Corps. For health reasons he left the service and moved to Florida where he continued in practice. Survivors include his widow, a son, two brothers and two sisters.

Charles P. Kennedy, M. D., Ft. Lauderdale, Fla.; University of Cincinnati College of Medicine, 1910; aged 68; died November 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Kennedy practiced for 40 years in Cincinnati before he moved to Florida about five years ago. Survivors include his widow, two daughters and a sister.

Joseph LaCamera, M. D., Akron; University of Cincinnati College of Medicine, 1927; aged 61;

died December 3; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. LaCamera was a practicing physician in Akron for 29 years. A veteran of World War I, he was a member of the American Legion and the Veterans of Foreign Wars. He was also a member of Phi Chi Fraternity, the Catholic Church, the Holy Name Society and the Sons of Italy in America. Surviving are his widow, a daughter, a son and three brothers, one of whom is Dr. Frank LaCamera of Warren.

Manley S. Lawrence, M. D., Quaker City; Ohio Medical University, Columbus, 1903; aged 81; died November 21; member of the Ohio State Medical Association, and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Lawrence began his practice in Orland, Ind., and from there went to Sarahsville. He moved to Quaker City in 1912. He was an elder in the Christian Church, served for many years as secretary of the local Masonic Lodge and was a member of the Rotary Club. Survivors include his widow, two daughters, two sons and a sister.

Robert W. Miller, M. D., Hemlock; University of Illinois College of Medicine, 1902; aged 81; died November 6 in a traffic accident; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; former member AMA. Dr. Miller practiced a total of 55 years, all of it in Hemlock and vicinity. He was serving as Perry County coroner. A member of the Masonic Lodge, last year was awarded the 50-year membership pin of the Knights Templar. Survivors include two daughters and a brother, Dr. James Miller, of Corning.

Herman H. Schulze, M. D., Cincinnati; Miami Medical College, Cincinnati, 1906; aged 77; died November 3; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Cincinnati for 51 years, Dr. Schulze had been presented the 50-Year Award of the Ohio State Medical Association. He was a member of the Masonic Lodge. Surviving are his widow; a son, Dr. A. Gordon Schulze, of Amelia; three brothers and two sisters.

Homer G. Scranton, M. D., Alliance; Western Reserve University School of Medicine, 1908; aged 74; died November 19; former member of the Ohio State Medical Association. A native of Alliance, Dr. Scranton served all of his professional career there. He was active in a number of community affairs, among them the Mount Union College building program. During World War I, he served in the Medical Corps and went to France as a captain in the 80th Division. He was a member of the Methodist Church, the Wranglers Club and Alpha Tau Omega. Surviving are his widow, a son and a sister.

Jefferson Davis Swango, M. D., Waterloo; Hahnemann Medical College and Hospital of Philadelphia, 1926; aged 59; died November 14; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Kentucky, Dr. Swango practiced in the Ashland, Ky., area and was physician for Armco Steel before he moved to Waterloo in 1930. He had been a practicing physician in that vicinity since and took an active part in local and county affairs. A veteran of World War II, he was a member of the Presbyterian Church and the Masonic Lodge. Surviving are his widow, two sons, his mother, two sisters and two brothers.

Albert L. Swartzwelder, M. D., formerly of Bartlett; Eclectic Medical College, Cincinnati, 1902; aged 79; died December 2. Dr. Swartzwelder practiced for about 25 years in the Cleveland area. After a short period in California he returned to Ohio and practiced in the Lawrence County area.

John W. Sheetz, M.D., Columbus; Johns Hopkins University School of Medicine, 1910; aged 72; died November 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Sheetz had been a practicing physician for many years in Columbus. He was a 32nd Degree Mason, a veteran of World War I and an active participant in Boy Scout work.

Raymond L. Thompson, M. D., Canton; Western Reserve University School of Medicine, 1916; aged 68; died November 21; member of the Ohio State Medical Association and the American Medical Association; past-president of the Stark County Medical Society. Dr. Thompson practiced for 37 years in Canton. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in the United Presbyterian Church. Survivors include his widow, a daughter, a son, his father and two brothers.

Edward B. Vogel, M. D., Bellevue; St. Louis University School of Medicine, 1920; aged 62; died November 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Vogel was a practicing physician in Bellevue from 1922 and was for many years physician for the Nickel Plate Railroad. He was a member of the local Board of Education for 12 years and was a councilman in the Catholic Church, a member of the Knights of Columbus, the Eagles and the Elks Lodge, and a member of the American Legion, being a veteran of World War I. Surviving are his widow, three sons, his mother, a sister and a brother.

Dr. William E. Shrontz, Newark High School's team physician for the past 17 years, was honored at the Zanesville-Newark football game. The program was jointly sponsored by the Newark High Athletic Association and the Newark Booster Club.



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Health Director Reports Influenza Seems on Wane; Recommended Vaccine Dosage Given

Dr. Ralph E. Dwork, director of the Ohio Department of Health, recently issued the following information to health commissioners throughout Ohio:

Informal reports from local health commissioners and fall in morbidity card reporting suggest that the peak in incidence of influenza has passed in the state of Ohio. Information obtained on school and industrial absenteeism indicate that this disease is spreading at a less rapid rate among adults than among children.

Reports of 85 deaths with influenza as a primary cause have thus far been received by the Ohio Department of Health. These do not represent the many cases in which influenza may have been a predisposing cause. Most of the major cities are still reporting more than the usual number of deaths due to influenza and pneumonia.

Influenza vaccine production has reached a stage where a sufficient supply should be available in most areas. Most influenza vaccine produced after December 1 will possess a potency double that of vaccine originally manufactured and thus should be a more effective immunizing agent. As a result, the Public Health Service now recommends the following in respect to dosage and method of vaccination:

1. As the 400 CCA Asian strain influenza vaccine becomes generally available, it is recommended that, for those who have not been vaccinated, the new vaccine be used in a single 1.0 cc. dose subcutaneously (injected under the skin).

2. For (a) those who have already received a 0.1 cc. dose intracutaneously of the 200 CCA vaccine, and for (b) those who have received a 1.0 cc. dose subcutaneously of 200 CCA vaccine, and who are in special risk groups: namely, pregnant women, the aged and those suffering from certain chronic ailments, such as rheumatic heart disease and chronic pulmonary disease, it is recommended that a second 1.0 cc. subcutaneous dose of 200 CCA vaccine or 0.5 cc. of 400 CCA vaccine be given in not less than two weeks after the first dose.

3. Physicians may also wish to recommend a second injection for other patients under their care.

4. For children, the recommendation for dosage of the American Academy of Pediatrics is: (a) For preschool children, under five years of age, 0.1 cc. intracutaneously or subcutaneously, repeated after an interval of one to two weeks. (b) For children of 13 years of age and older, the dose for adults, 1.0 cc. subcutaneously in a single injection, may be used.

It should be noted that the changes are recom-





mended for especially exposed groups rather than those immunized according to the previously recommended schedule.

The accompanying map indicates the counties wherein influenza outbreaks, laboratory confirmations and deaths have occurred.

New Identification Card Under Medicare Program To Be Issued Soon

It is expected that by January 1 the new identification card for dependents of persons in the uniformed services will be in general use. As soon as distribution has been made this card, DD Form 1173, "Uniformed Services Identification and Privilege Card," will be used to identify persons eligible for medical care under the Medicare Program **provided** the card so indicates.

These are essential points for the physician to remember in regard to the new cards:

1. As soon as distribution has been made (about January 1) this card will be required to identify persons eligible for Medicare privileges.
2. Holders of the card are eligible for Medicare services only if such authorization is indicated by the word "Yes" before "Civilian" under Item 14.
3. Normally, children under ten years of age will not be issued cards, and identification will be made by parents or guardians.

"As far as we know now these cards will be necessary after January 1," reported J. J. Wrabetz, administrator of the Dependents Medical Care for Mutual of Omaha.

Following are quotes from a communication from Maj. Gen. Paul I. Robinson, executive director, Office for Dependents' Medical Care in Washington:

"DD Form 1173 is now entitled 'Uniformed Services Identification and Privilege Card' and is being issued to all persons eligible for Medical Care, commissary privileges, exchange patronage, admission to military theaters or who require military identification. Essentially then, issuance of this card will be to a far greater number of persons than those eligible for medical care under the Program. Benefits authorized by the card are indicated on the card and the controlling factor, in respect to determining eligibility for care, is the entry of the word 'Yes' preceding the word 'Civilian' in Item 14. When civilian medical care is not authorized, Item 14 'Civilian' will be blocked out on the card.

"This card will not normally be issued to children under ten years of age. When cards are not issued to these children, the identification of the accompanying parent or guardian signing the statement is considered acceptable. This can be accomplished by review of either the DD Form 1173, carried by the mother, or the "Identification Card" of the parent who is a member of a uniformed service. . ."

Governor Names Three Boards To Hear Appeals on Issuance of Drivers' Licenses for Epileptics

Members of three review boards consisting of three physicians each have been appointed by Governor C. William O'Neill to hear appeals in regard to issuance of drivers' licenses for epileptics.

Under the new law, Amended House Bill 569, which became effective September 17, epileptics whose seizures have been under effective control for at least a year may apply for drivers' licenses. The applicant must present a certification from a physician that his condition is under effective medical control. (Refer to September issue of *The Journal*, page 1065.)

If the registrar of motor vehicles sees fit to deny an applicant a driver's license, the applicant may appeal to one of the review boards. The Governor has appointed three appeal boards, one each in Cincinnati, Columbus and Cleveland for convenience in handling appeals.

Following are the names of physicians appointed to the boards:

Cincinnati—Dr. Howard D. Fabing, Dr. Douglas Goldman and Dr. Hiram B. Weiss.

Columbus—Dr. Harry LeFever, Dr. Dwight M. Palmer and Dr. Milton M. Parker.

Cleveland—Dr. Edward O. Harper, Dr. Louis J. Karnosh and Dr. John H. Nichols.

University of Cincinnati Announces Short Course in Nasal Surgery

The Department of Otolaryngology, University of Cincinnati College of Medicine, announces a Course in Reconstructive Surgery of the Nasal Septum and External Pyramid. The course will be under the direction of Dr. Maurice H. Cottle, professor of otolaryngology, Chicago Medical School, and a selected faculty in association with the American Rhinologic Society, April 12 through April 19. Class membership is limited. Tuition is $350.00. Please apply to Dr. Henry M. Goodyear, professor of otolaryngology, College of Medicine, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

ADAMS

The president, vice-president and secretary of the Adams County Medical Society for 1958 will be the same as those for 1957, all being re-elected at the fall meeting. They are Dr. Sam Clark, president, Cherry Fork; Dr. S. B. Sonkin, West Union, vice-president, and Dr. Hazel Sproull, West Union, secretary-treasurer.

CLERMONT

Dr. Vincent J. Seiwert, Cincinnati, was speaker at the regular meeting of the Clermont County Medical Society at the D-X Ranch on October 23.

HAMILTON

On December 3 the Academy of Medicine of Cincinnati had as guest speaker Dr. Frederic E. B. Foley, clinical professor of urology, University of Minnesota, St. Paul, who presented the subject, "Surgical Treatment of Hydronephrosis." Included in the presentation was a motion picture demonstration of the Foley Y-Plasty.

Honored at this meeting for a half century of devotion to the medical profession were the following physicians: Drs. Frank W. Case, Edwin W. Enz, Charles W. Metz, F. H. Miketta and Thomas R. Dickson, all of Cincinnati; Dr. Robert C. Allen, Glendale; Dr. Earl S. Simmonds, St. Petersburg, Fla., and Dr. K. L. Weber, Venice, Fla.

Dr. Frank H. Mayfield, Councilor of the First District, presented 50-Year Awards in behalf of the Ohio State Medical Association.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Dr. E. W. Schilke became the 76th president of the Clark County Medical Society when the 107-year-old organization elected and installed officers for 1958.

The election was the highlight of the November 18 meeting in Hotel Shawnee, Springfield.

Dr. Schilke, a member of the Clark County Medical Society since 1943, was 1957 president-elect. He succeeds Dr. John D. Le Fevre.

Members elected Dr. William P. Montanus of Springfield as 1958 president-elect.

Other new officers are Dr. Martin J. Cook, secretary; Dr. Naoma D. Green, treasurer; Dr. Ray M. Turner and Dr. John M. Summers, delegates, and Dr. J. Harold Shanklin and Dr. Schilke, alternates.

Society President Schilke completed his undergraduate work at Nebraska Wesleyan University, Lincoln, Neb., in 1937.

He was graduated from the University of Nebraska College of Medicine, Omaha, Neb., in 1942. He interned at City Hospital in Springfield from 1942 to 1944.

Dr. Schilke was a captain in the Army from 1944 to 1946, serving in Europe and Japan. He served the society as secretary and delegate in 1949.

Besides Dr. Le Fevre, retiring officers are Dr. Charles E. Fralick, secretary, and Dr. George P. Fitzgerald, Jr., treasurer.

Guest speaker at the meeting was Dr. John M. Sheldon of the department of post-graduate medicine at the University of Michigan. His topic was "Drug Allergies."

Dr. B. H. Marks, associate professor in the department of pharmacology and physiological chemistry at Ohio State University's College of Medicine, was the guest speaker at the October 21 meeting of the society.

Dr. Marks' topic was "Lipid Metabolism and Atherosclerosis."

The meeting also marked the society's announcement of a public relations report on Asian flu vaccine. The report, in general, told Springfielders to contact family physicians if they are not sure if they should receive the vaccine.

The report was prepared by Dr. Edwin Ash, chairman of the public relations committee.—Tom Duross, Exec. Secretary.

DARKE

Dentists of the area were guests at the November 19 meeting of the Darke County Medical Society. The dinner meeting was held in the Treaty City White Shrine Temple, Greenville. The speaker for the occasion was H. R. Franklin, of the Medical Protective Company, whose subject was "Malpractice Prophylaxis."

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

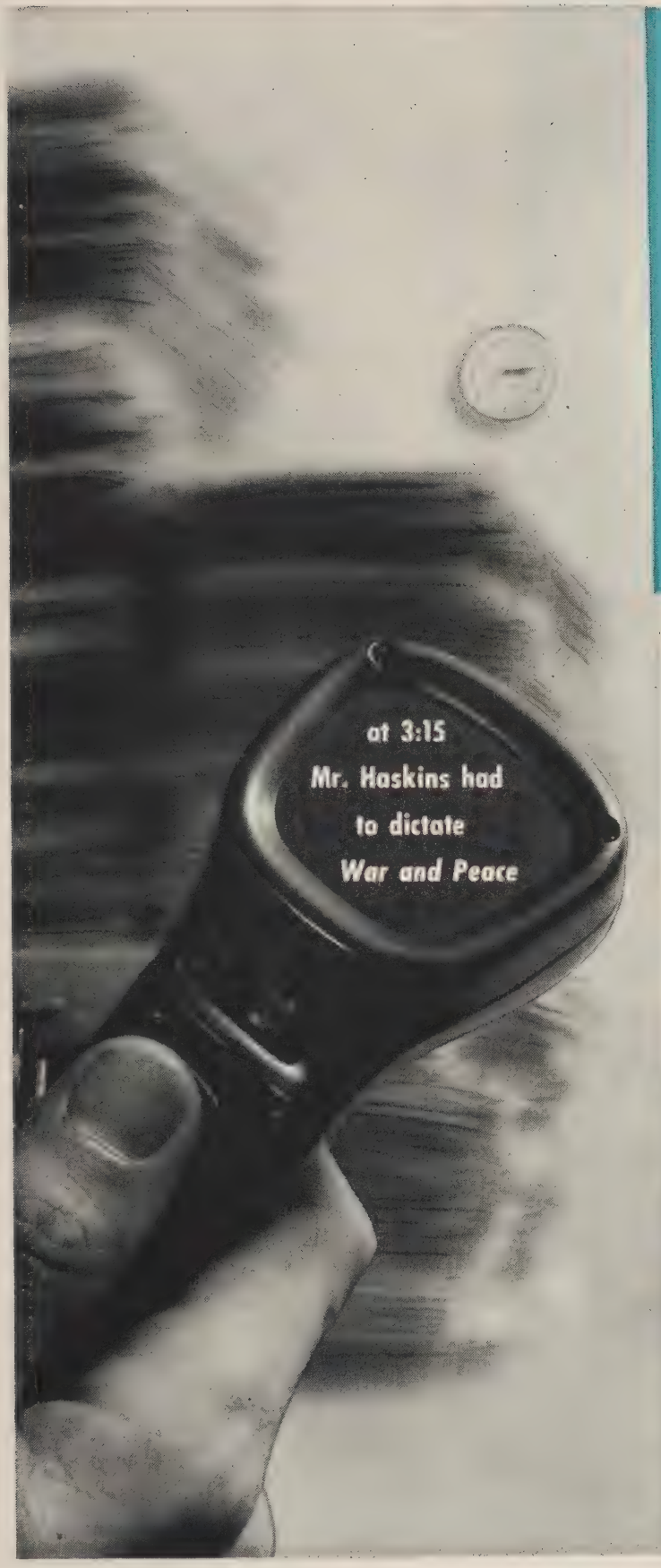
Dr. R. L. Tecklenberg was named president-elect of the Allen County Academy of Medicine at a meeting held November 19 in Lima. Dr. T. D. Allison was elected secretary and Dr. D. L. Becker, treasurer. Dr. Walter E. Yingling assumes office as president in January.

Speaker for the clinical program was Dr. Arthur D. James, associate professor of surgery at Ohio State University, whose subject was "A Lump in the Throat."

The Academy's annual dinner dance was held on December 10.

MARION

A half century of service in the practice of medicine was rewarded when a 50-Year Pin was conferred upon Dr. Maude E. Bull at a dinner



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meeting of the Marion Academy of Medicine held in the Hotel Harding, Marion, in early December.

Making the presentation was Dr. James R. Jarvis, Van Wert, Councilor of the Third District, while Dr. John T. Boxwell, president of the local academy, gave congratulations on behalf of her fellow doctors.

New officers were elected at the annual meeting of the Academy.

Dr. Dan Murphy was named president; Dr. Thomas Quilter, vice-president; Dr. James Schuler, secretary-treasurer; Dr. John T. Boxwell, trustee for three years and Dr. J. W. Bull, trustee for two years.

For the scientific portion of the meeting, a movie taken from a closed circuit telecast from Boston was shown. It was entitled "Problems in Acute Abdominal Pain."

VAN WERT

Dr. S. A. Edwards was guest of honor at a dinner at the First Presbyterian Church, Van Wert, on November 20 to which the public was invited. The occasion was his completion of 50 years of practice, most of that time in the Middle Point and Van Wert area. Speaking at the occasion was Dr. Robert S. Martin, Zanesville, President of the OSMA. Dr. James R. Jarvis, Van Wert, Councilor of the Third District, was in charge of arrangements for the affair, and Kerns Wright, local attorney, was toastmaster.

Fourth District

(COUNCILOR: PAUL E. ORR, M. D., PERRYSBURG)

LUCAS

The December schedule of the Academy of Medicine of Toledo and Lucas County contained the following features:

December 6—Annual business meeting.

December 13—Pathology Section: "Diagnosis and Treatment of Constrictive Pericarditis," Dr. Voja Stojanovic, chief of the Department of Surgery, Belgrade University, Yugoslavia.

December 20—Medical Section: "Influenza, Echo and PAC Viruses as Related to Clinical Medicine," Dr. Winslow Bashe, chief epidemiologist, Ohio Department of Health, Columbus.

WOOD

Dr. Stewart J. Smith was elected president of the Wood County Medical Society at the organization's regular monthly dinner meeting at the Midway Restaurant, Bowling Green, on November 21. He succeeds Dr. Victor Pilliod, of Grand Rapids.

The new vice-president is Dr. Roger A. Peatee. Dr. Richard L. Pearse was re-elected secretary-treasurer. The three new officers are from Bowling Green.

The scientific program consisted of a film on

premalignancies and malignancies of the breast and colon.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

Five members of the Academy of Medicine of Cleveland were honored by being awarded the 50-Year Pin and Certificate of the Ohio State Medical Association at a program on November 15. The occasion was the Academy's annual William E. Lower Lecture.

Those honored were: Dr. Clyde L. Cummer, past-president of both the Cleveland Academy and the Ohio State Medical Association; Dr. Frank J. Keeley, Dr. Martin M. Mandel, Dr. William W. Starrett and Dr. James G. Warner.

Speaker was Dr. Chester S. Keefer, professor of medicine at Boston University and physician-in-chief at Massachusetts Memorial Hospitals. He discussed current problems relating to infections and their control.

On November 28, Catherine Drinker Bowen, author and lecturer, spoke to a joint meeting of the Academy of Medicine and the Cleveland Bar Association. Her subject was "Lawyers, Politics and Courage."

GEAUGA

Dr. Hugh Schaffer, of Middlefield, was elected president of the Geauga County Medical Society at a dinner meeting on November 8. Dr. George Dandalides, of Chardon, was elected vice-president, and Dr. Alton Behm, Chardon, secretary-treasurer. Retiring president of the Society, Dr. Walter C. Corey, was elected delegate.

LAKE

Officers of the Lake County Medical Society for 1958 are the following: Dr. Robert A. Irvin, president; Dr. Richard McBurney, vice-president; Dr. Gorden W. Hasse, secretary-treasurer; Dr. B. S. Park, delegate, and Dr. James G. Powell, alternate.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

Three physicians were honored for faithful service in the medical profession over a half century at the November 14 meeting of the Stark County Medical Society in Canton. They are Dr. H. W. Bell, Dr. H. H. Bowman and Dr. Isadore Fuchs. Dr. C. A. Gustafson, Youngstown, Sixth District Councilor, presented each the 50-Year Pin of the Ohio State Medical Association.

SUMMIT

The Summit County Medical Society has taken on its first full-time executive secretary. He is Sidney H. Mountcastle who for the past six years

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has directed the American Cancer Society's Canton-Stark County Unit. While carrying on his new duties in Akron he plans to maintain his present home on the Cairo-Mount Union Road near Hartville.

Mountcastle is a native of Lakewood and a graduate of Kent State University where he studied journalism and public relations. He has also had special studies in adult education at Mount Union College. During World War II he served with the Marine Corps.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Annual Banquet of the Scioto County Medical Society was held on December 12 at the Elks City Club in Portsmouth. Following the social hour and dinner, entertainment was presented after which an evening of dancing was enjoyed.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Eleven of the 26 living Past-Presidents of the Columbus Academy of Medicine were present at the Annual Banquet on December 7 in the Neil House. Senior of the Past-Presidents was Dr. J. H. J. Upham who headed the Academy in 1914. Dr. Upham also is Past-President of the Ohio State Medical Association and of the AMA.

For the first time each of the Past-Presidents was presented a lapel pin from the Academy by Dr. Norman O. Rothermich, President.

Dr. Harley O. Bratton was presented the 50-Year Award by Dr. Edwin H. Artman, Chillicothe, Councilor of the Tenth District. Other members eligible to receive 50-Year Awards from the Ohio State Medical Association this year but not present are Dr. Carl D. Hoy and Dr. Forrest L. Keiser.

ROSS

The following report is from the *Chillicothe Gazette:*

Dr. Lewis Coppel was elected president of the Ross County Medical Association at a meeting held at the Gold Key, November 8. He succeeds Dr. Charles N. Hoyt.

Other officers elected were: Dr. Robert E. Quinn, vice-president; Dr. William M. Garrett, secretary-treasurer; Dr. Robert E. Swank, delegate to the Ohio State Medical Association, and Dr. Ralph W. Holmes, alternate to OSMA.

Dr. Holmes, who has been delegate to OSMA off and on since 1902, is now in semi-retirement and has retired to the alternate position.

Dr. Quinn was the speaker of the evening, discussing "Eye Diseases."

UNION

Doctors of Union County held a party on November 16 in celebration of Dr. P. D. Longbrake's 60th year in devotion to the medical profession. Colleagues presented Dr. Longbrake with a wall clock. Dr. Longbrake started his practice in Shelby but moved to St. Marysville 56 years ago.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held November 12 at Oberlin Inn. The society had as guests members of the Lorain County Bar Association. Approximately 130 members and guests were present at one of the largest turn-outs in the history of the society.

Speaker of the evening was Dr. Lester Adelson, chief deputy coroner for the County of Cuyahoga. His well accepted and interesting speech pertained to sudden death as related to the coroner.

The joint expression of those present at the dinner meeting was that it was a most successful meeting, and it is hoped that such an affair will be repeated.—Conrad T. Rusin, M. D., Secretary-Treasurer.

Deadline for Getting Special Auto Tags is February 15

Members of the Ohio medical profession who desire 1958 automobile license plates bearing the word "Physician" have until February 15 to have their applications for the special tags in the hands of the Bureau of Motor Vehicles, Columbus 16.

Physicians who had the special tags in 1957 were mailed applications for 1958 plates during December by the Motor Vehicle Bureau.

Although a state law provides a physician may obtain such tags if he so desires, **there is nothing in the law that makes it compulsory.**

Some physicians feel the tags are a special invitation for narcotics addicts and thieves to loot the doctor's car, attract undue attention and involve the doctor in nuisance types of cases.

Ohio physicians who may want to obtain the tags for the first time in 1958 should write to the Bureau of Motor Vehicles for application forms. One of these forms is a certification of medical licensure which the physician must have executed and signed by the State Medical Board, 21 W. Broad St., Columbus.

Last year a number of physicians mailed these certifications to the OSMA Headquarters Office. The State Association is not empowered to certify these forms under the law. They must go to the State Medical Board.

The Bureau of Motor Vehicles also emphasized that the vehicle for which the license plates are used must be registered in the name of and the application must be in the name of the physician who obtains the plates. This requirement means that the Ohio State Medical Association Headquarters cannot process such applications since the Bureau requires that the physician apply directly to the Bureau.

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...spreads in a wink



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...Just drop on eye...spreads in a wink! Provides unsurpassed antibiotic efficacy in a wide range of common eye infections...dependable prophylaxis following removal of foreign bodies and treatment of minor eye injuries.

SUPPLIED: 4 cc. plastic squeeze, dropper bottle containing ACHROMYCIN Tetracycline HCl (1%) 10.0 mg., per cc., suspended in sesame oil...retains full potency for 2 years without refrigeration.

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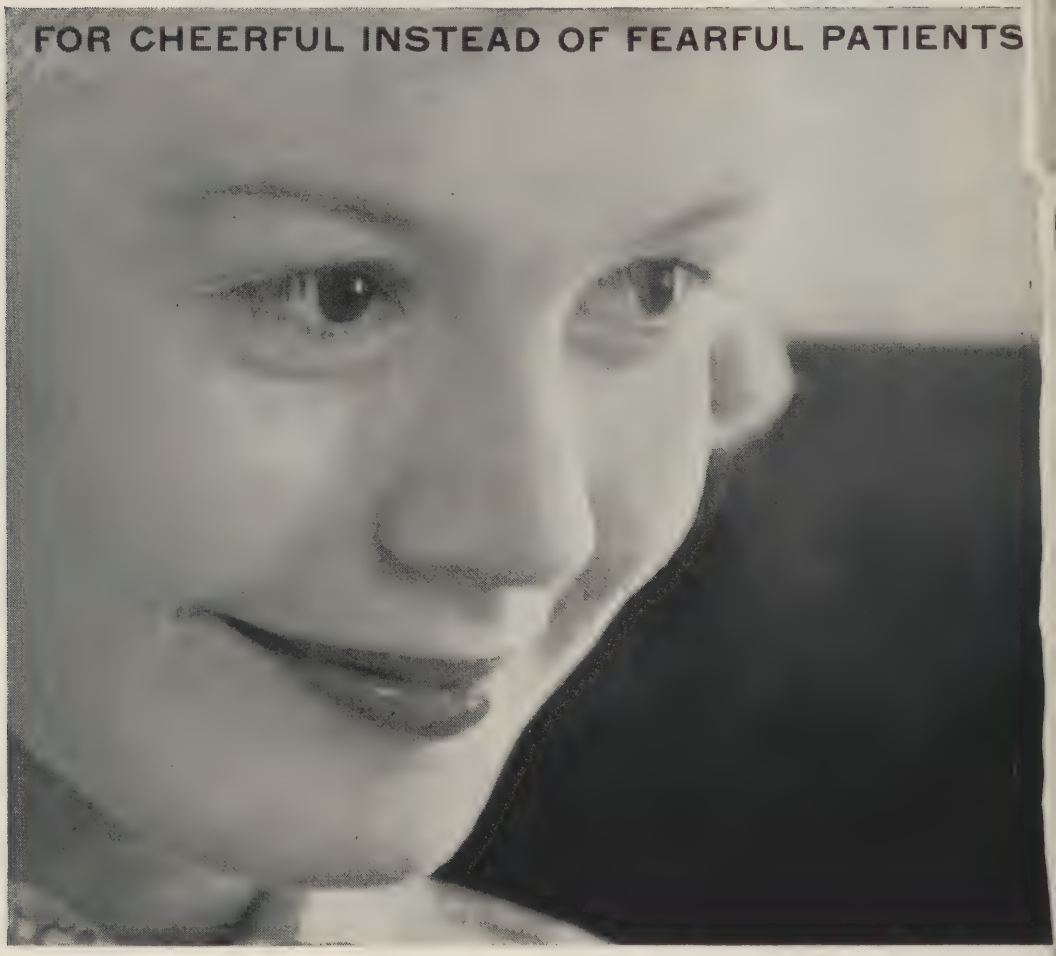
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New Isuprel-Franol tablets bring round-the-clock relief *plus* emergency help against sudden attack. Anxiety stops when patients know they'll get relief in 60 seconds — relief that continues for four hours or more.

Isuprel HCl (10 mg. for adults, 5 mg. for children), the most potent bronchodilator known, makes up the outer coating. In a sudden attack, the patient puts the tablet under his tongue. Relief starts in 60 seconds. A unique feature is the "flavor-timer." As the Isuprel is absorbed a lemon flavor appears. When it disappears—about five minutes later — the patient swallows the tablet.

An unexcelled combination for prolonged bronchodilatation makes up the Isuprel-Franol core: benzylephedrine HCl (32 mg.), Luminal® (8 mg.) and theophylline (130 mg.). Swallowed, the tablet works for four hours or more.

Isuprel-Franol tablets are "... effective in controlling over 80% of patients with mild to moderate attacks of asthma."[1]

1. Fromer, J. L., and DeRisio, V. J.: *Lahey Clin. Bull.* 10:45, Oct.-Dec., 1956.

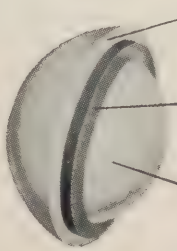
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Sig. 1 tablet t. p. d.
If attack occurs, place 1 tablet under tongue, swallow after five minutes.

ISUPREL-FRANOL tablets (Isuprel HCl 10 mg.) for adults;
ISUPREL-FRANOL Mild tablets (Isuprel HCl 5 mg.) for children:
One tablet every three or four hours taken *orally* for continuous control of bronchospasm in chronic asthma. One tablet taken *sublingually* for sudden attack. "Flavor-timer" signals when patient should swallow.
Bottles of 100 tablets.

"Flavor-timer" signals patients when to swallow tablets



ISUPREL
Immediate effect sublingually—for emergency use

LEMON "FLAVOR-TIMER"
Disappearance of flavor is the signal to swallow

FRANOL { Theophylline / Luminal / Benzylephedrine
Sustained action—reduces frequency and intensity of attacks

ISUPREL (BRAND OF ISOPROTERENOL), FRANOL AND LUMINAL (BRAND OF PHENOBARBITAL), TRADEMARKS REG. U. S. PAT. OFF.

Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. C. H. Bell, 754 Dickson Parkway, Mansfield
(See Page 5 for roster of officers.)

DISTRICT 1

The Woman's Auxiliary to the Hamilton County Medical Society was host to doctors' wives from seven neighboring counties at a meeting of the First District of the Woman's Auxiliary to the Ohio State Medical Association on November 19 at the Hotel Sinton. Mrs. V. R. Frederick, state president; Mrs. G. T. Harding III, third vice-president; and Mrs. Herbert Warm, director of District 1, spoke. The meeting was followed by the regular luncheon of the local auxiliary and a talk by Miss Venita Kelly, fashion editor of the *Cincinnati Post*. In the evening, auxiliary members were their husbands' guests at the meeting of the Cincinnati Academy of Medicine for a symposium on estate planning.

Forty-two members who volunteered two weeks of concentrated work as notaries for disabled voters in eight Greater Cincinnati hospitals were honored at a post-election tea at the home of their chairman, Mrs. John D. Marioni.

New members assembled for a coffee hour and orientation meeting at which auxiliary officers, directors, and committee chairmen interpreted for them the aims and activities of the organization. Three informal gatherings of this kind are planned by the New Members Orientation Committee, headed by Mrs. Clark S. Fitzmorris.

Sale of Christmas cards to benefit the AMEF was again conducted this year.

DISTRICT 2

The Woman's Auxiliary to the Clark County Medical Society was hostess to District 2 on October 24, for a luncheon at the Springfield Country Club. Mrs. Harvey J. Staton, director, was the presiding officer for the day.

Mrs. V. R. Frederick, state president; Mrs. M. J. Towle, corresponding secretary; and Mrs. Morton Block, Chairman, *Today's Health* were the state officers attending the meeting. Total attendance for the day was 53—36 from Clark County; 10 from Montgomery; 5 from Champaign; 2 from Miami.

Dr. John Stauffer, dean of men, Wittenberg College and president of the community welfare council, was the guest speaker, his topic being "Mental Health."

Mrs. A. T. Anton and Mrs. George Fitzgerald, Jr., were in charge of arrangements. Program committee consisted of Mrs. J. F. Harley, Mrs. C. W. Hullinger, Mrs. S. C. Yinger and Mrs. H. B. Elliott.

DISTRICT 3

The Third District Woman's Auxiliary to the Ohio State Medical Association met at the Findlay Country Club for lunch on October 9.

Following the luncheon, Mrs. Ralph Rasor, president of Hancock County, welcomed the members. A musical program was presented by Allen Dudley and Mrs. William H. O'Brien. Mrs. Rasor then introduced the state officers as follows: Mrs. V. R. Frederick, president; Mrs. W. R. Gibson, president-elect; Mrs. M. J. Towle, corresponding secretary; Mrs. Karl Ritter, parliamentarian; Mrs. Warren Mills, American Medical Education Foundation; Mrs. Myron Thomas, members-at-large; Mrs. Stephen P. Churchill, director of District 3; Dr. J. R. Jarvis, advisory board. Dr. Jarvis is serving his fifth year as a member of the three-man board of advisors to the State Auxiliary.

Mrs. V. R. Frederick was the guest speaker. She urged each county to reappraise its own organization, remembering the word, MOPS—Methods for effective, Objectives, Projects, and Service. She stressed the importance of the American Medical Education Foundation.

Mrs. Walter Galbreath was chairman for the luncheon and was assisted by Mrs. Robert T. Miller and Mrs. Robert Traul.

DISTRICT 6

Stark County was hostess to 140 district auxiliary members on October 23 when the annual sixth District Meeting was held in Canton. Following registration and coffee, a luncheon and style show were held in the private rooms of a local restaurant. The women then met their husbands for a reception given by the Bowman Brothers Drug Co. before the evening banquet.

Mrs. Richard Spitzer, Stark County president, welcomed the guests and introduced Mrs. George Wilcoxon, Sixth District director, who in turn presented the State Officers and Board members present. Mrs. V. R. Frederick, State President, gave a short talk concerning the aims of the Auxiliary for the coming year.

DISTRICT 8

The Woman's Auxiliary to the Washington County Medical Society entertained 45 members at the annual Eighth District Auxiliary, October 3 at Hotel Lafayette.

Highlighting the meeting was a fashion show presented by Hanes. Models were from the Marietta Welfare League.

Mrs. T. R. Mattocks, Washington County president, introduced Mrs. Frederick James, Eighth District director of Lancaster, who in turn introduced Mrs. V. R. Frederick, state president. Mrs. Frederick urged support of *Today's Health*, the American Medical Educational Foundation, driving education in the schools and distribution of health wallet cards.

Mrs. S. L. Meltzer of Portsmouth, 1st vice-president of the State Auxiliary and advisor to the Eighth and Ninth Districts, spoke about her

relaxes both mind & muscle

without impairing mental or physical efficiency





well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

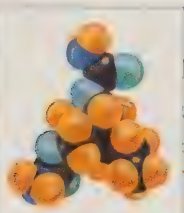
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For anxiety, tension and muscle spasm in everyday practice.

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'Miltown' therapy resulted in complete relief from symptoms in 88% of pregnant women complaining of insomnia, anxiety, and emotional upsets.*

'Miltown' (usual dosage: 400 mg. q.i.d.) *relaxes both mind and muscle* and alleviates somatic symptoms of anxiety, tension, and fear.

'Miltown' therapy does not affect the autonomic nervous system and *can be used with safety throughout pregnancy.**

**Belafsky, H. A., Breslow, S. and Shangold, J. E.: Meprobamate in pregnancy. Obst. & Gynec. 9:703, June 1957.*

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duties. Mrs. Myron Thomas, chairman of members-at-large discussed AMEF and members-at-large. Mrs. Thomas also passed the $85.00 East hat belonging to Mrs. David Thomas from Pennsylvania. This is the hat that has collected so much money for AMEF.

Mrs. Deane Northrup was chairman of arrangements, assisted by Mrs. N. M. LaBarre, Mrs. Edgar Northrup and Mrs. Ford Eddy.

A cocktail and dinner party held at the Marietta Country Club (with doctor husbands) concluded a very successful meeting.

DISTRICT 9

Fifty-two doctors' wives, including 24 from Scioto County, were present for the annual meeting of District 9, held at Lake White Club.

Mrs. George W. Cooper of Waverly, 9th District director, presided at the afternoon luncheon meeting at which members of the Pike County Auxiliary served as hostesses.

The State President, Mrs. V. R. Frederick of Urbana, was the main speaker. Dr. Carter L. Pitcher of Portsmouth, advisory committee member, also gave a short talk. Other brief talks were made by Mrs. Samuel Meltzer, Mrs. M. J. Towle, Mrs. Myron Thomas and Mrs. Walter Kramer.

Scioto, Pike, Lawrence, Meigs, Gallia, Vinton, Hocking and Jackson counties comprise District 9. The Auxiliary presidents also spoke briefly. They were Mrs. A. M. Shrader of Pike, Mrs. Charles Gallagher, Lawrence; Mrs. John Cook, Jackson; and Mrs. Armin Melior of Scioto. Gallia County, which is not organized, had three members-at-large introduced.

A program of piano music was presented by Mrs. R. O. McFerrin. Special entertainment by Mr. and Mrs. Robert Hurth of Portsmouth demonstrated ballroom dancing and other special dances.

DISTRICT 10

The Woman's Auxiliary to the Delaware County Medical Society entertained the Union, Morrow, Knox, and Franklin County Auxiliaries on October 15 with a luncheon at the Mar-Jon Tea Room.

Judge Henry Robinson, who is associated with the Franklin County Hospital Federation, spoke on institutional phases of welfare work with particular reference to older and younger generations.

Mrs. V. R. Frederick, state president, outlined the aims of the Auxiliaries for the coming year and discussed special recommendations from the American Medical Association.

Mrs. D. L. Gantt, local president, conducted a short business meeting and state conference reports were given. Mrs. E. C. Jenkins and Mrs. Walter Kramer of Chillicothe, director of District 10, were in charge of arrangements for the day.

* * *

BUTLER COUNTY

Mrs. Peter Ammentorys and Mrs. William Neel of Middletown and Mrs. H. Sheffield Jeck of

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MENOPAUSE
DESERVES
"PREMARIN"

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Oxford were introduced as new members of the Woman's Auxiliary to the Butler County Medical Society on October 22, at a luncheon at Eaton Manor in Hamilton.

Speaker for the afternoon was Mrs. Muriel Allen, executive director of the Hamilton Senior Citizens Center. Mrs. Allen described the founding of the center in 1954 and its growth to an expected membership of 800 by the end of this year. Hamilton members act as hostesses at the center at intervals throughout the year.

Luncheon arrangements were in charge of Mrs. Carl Leyrer, Mrs. Ralph Leyrer, Drs. David Zensky, Mrs. Richard Mense and Mrs. Judd Uhl.

DELAWARE COUNTY

A nurse recruitment tea, sponsored by the Delaware County Auxiliary, was held on October 31 in the lounge of the nurses' residence of Jane M. Case Hospital. Twenty-two students were present, representing Elm Valley, Willis and Olentangy High Schools.

Mrs. C. Hoffman, director of nurses, and Richard Claar, superintendent of Jane M. Case Hospital, spoke to the group and conducted a tour through the new addition to the hospital.

Hostesses for the tea were Mrs. E. C. Jenkins and Mrs. M. L. Livingston.

MAHONING COUNTY

Keyed to the gaiety of the season was an informal dance and fall frolic held by the Mahoning County Auxiliary on November 2 in the ballroom of Hotel Pick-Ohio. The occasion was the annual benefit staged for the benefit of the nurses' scholarship fund. Sharing in the benefit also will be the American Medical Educational Foundation.

Heading the hostess committee was Mrs. Robert Tornello, chairman, assisted by Mrs. Harold Chevlen, Mrs. A. A. Detesco, Mrs. Gene Fry, Mrs. A. W. Geordan, Mrs. Louis Zeller, Mrs. Wayne Agey and Mrs. Fred Schellhase.

SUMMIT COUNTY

The Summit County Medical Auxiliary held a luncheon meeting on November 5 at the Smorgasbord in Stow. Mrs. Frederick Sterbenz was the speaker. Mrs. Sterbenz is a former newspaper woman who has traveled in Europe, the Orient, Mexico and Panama with her husband who is the foreign editor of the *Cleveland Press*. The title for her talk was "Under Your Hat" in which she displayed six hats from a different period and with a different story. Mrs. Henry Allison, program chairman, introduced the speaker.

Following the talk, Mrs. R. R. Pliskin, president, presided for the business meeting.

RICHLAND COUNTY

Forty-eight members of the Richland County Auxiliary met for luncheon at the Women's Club on November 4. Mrs. Milton Oakes introduced the speaker, Miss Jane Magruder, information representative for the Ohio Fuel Gas Co. Miss Magruder's topic was "Wonderland" and told how nature changed prehistoric plant and animal life into natural gas and how man now turns natural gas into useful products for modern living.

Following the program, a business session was conducted by Mrs. Paul Lee, president. Various committee reports were given. Mrs. Frank Ternocky reported on recent legislation; Mrs. Robert Tawsee, Nurse Recruitment chairman, reported on a project of the Future Nurses Club to defray expenses for field trips. Mrs. Carl Damron reported on Ways and Means.

Hostesses for the day were Mrs. Joseph Seibert, Mrs. Russell Long, Mrs. Charles Curtis and Mrs. Robert Harsh.

Ophthalmology Course Scheduled At Ohio State University

The Department of Ophthalmology, Ohio State University College of Medicine, is presenting a postgraduate course in ophthalmology on Monday, March 3, and Tuesday, March 4. The program begins with registration at 8 a. m. in the Ohio Union Building, OSU Campus.

Registration may be made by writing: William H. Havener, M. D., Department of Ophthalmology, University Hospital, Columbus 10, Ohio. Fee is $20.

A program has been planned for ladies who accompany their husbands to Columbus.

The program for the course includes the following speakers and topics:

"Intraocular Malignant Melanoma," Dr. Havener.

"Intraocular Diseases Simulating Melanoma," Dr. Algernon B. Reese, New York City.

"Enucleation, Evisceration, Extenteration," Dr. F. Bruce Fralick, University of Michigan.

"Incidence of Unsuspected Melanoma," Dr. Torrence A. Markley, Ohio State University.

"Stereoscopic Indirect Ophthalmoscopy for the Diagnosis of Intraocular Tumors," Dr. Charles L. Schepens, Boston, Mass.

"Surgical Errors in the Management of Tumors," Dr. Fralick.

A dinner meeting will be held at 6:30 p. m. Monday with the Columbus Academy of EENT, following which Dr. Reese will speak on "Orbital Tumors."

Tuesday morning's program will begin at 8:00 a. m. with a movie on embryology of the eye. Topics and speakers for Tuesday are:

"Principles of Lid Surgery," Dr. Fralick.

"Radiotherapy of Eye Lesions," Dr. Reese.

"Retinal Detachment," Dr. Schepens.

"Retinoblastoma Inheritance," Dr. Madge T. Macklin, Ohio State University.

"Retinal Detachment," Dr. Schepens.

"Sinus Neoplasms," Dr. William H. Saunders, Ohio State University.

Inflation and Medical Costs . . .

What Has Been the Effect of Inflation on the Costs of Medical Care, Hospital Care, Physicians' Fees, and Costs of Numerous Other Services?

PHYSICIANS, as well as all citizens, should —must—be interested in the alarming problems caused by inflation which are now the subject of study by government officials and of conversation whenever people get together.

What has been the effect of inflation on the costs of medical care, costs of hospital care, costs of doing business, physicians' incomes, costs of other services which the average citizen purchases day by day?

An excellent article, "Inflation and Medical Care" appeared in the October, 1957, issue of *The Journal of the AMA*. Thinking that perhaps some of its readers may have missed the article, *The Journal of the OSMA* is reproducing it here, hoping that all who have not read this thought-provoking analysis of a critical situation will do so:

* * *

TEXT OF ARTICLE

Since medical care and those who deliver it are integral parts of the American economy, it is well to take stock of the position of medical care in the current inflationary spiral. This period of inflation started in 1940 and continued through and after World War II, through the Korean war, and down to the present time with only minor interruptions.

Five historical comparisons reveal the relative degree of inflation in the medical care sector: (1) commodity versus service price indexes, (2) medical care indexes versus the entire Consumer Price Index, (3) changes in the absolute and relative amounts of personal consumption expenditures for medical care, (4) changes in the percentages of one week's wages required to purchase a fixed amount of medical care, and (5) comparisons of the rate of increase in the average level of incomes of physicians with those for all gainfully employed persons.

During World War II the national debt increased from about 50 billion to 280 billion dollars in the form of government bonds; from the standpoint of their inflationary effects, these bonds may be regarded as greenbacks bearing interest.

As has been true in earlier war cycles, prices of commodities and services were higher after World War II than they were during the war. Moreover, in a long inflationary period there is always a tendency for the prices of commodities to rise first and the prices of services to lag behind and rise later. It would be expected then that medical care prices in this long period would rise more slowly at first and more rapidly later. This is precisely what has happened.

SERVICE PRICES STILL LAG

Consumer price indexes of the United States Bureau of Labor Statistics covering all the commodity prices which are included in the sample stood at 208.2, or 108 per cent above the 1935-1939 level in 1956; on the basis of the 1947-1949 level, the index was 109.8.

The important point to observe, however, is that this 1956 index for all commodities (excluding services) on the basis of the long period was 208 as compared with only 194 for the entire (including services) Consumer Price Index; but on the basis of what has happened since 1949, this index for 1956 was a seemingly modest 109.8 as compared with the Consumer Price Index of 116.2. On the other hand, the index for all services (excluding commodities) on the basis of what has happened since 1940 was 185.2 in 1956, or less than the Consumer Price Index of 194.3. But on the basis of what has happened since 1949 only, the short-run period, the index for all services was 135.1, or definitely higher than the Consumer Price Index on this short-run basis. One can conclude, therefore, that on the basis of the entire inflationary period commodity prices have risen a good deal more than service prices, 208 over 185; the latter are still in the "catching up" stage.

LANGFORD ARTICLE

This lag in service prices, and in medical care prices in particular, is stressed in an article by Elizabeth A. Langford[1] of the U. S. Bureau of Labor Statistics in the September issue of the *Monthly Labor Review*, the official publication of the U. S. Department of Labor. In a summary of the changes in the two decades she states (page 1053):

"Medical care prices followed about the same pattern as those for all services. Thus, at the end of 1956, the prices of services, including medical care, had almost regained the relationship they held with the prices of commodities in the midthirties. Since the Consumer Price Index measures price changes relative to 1947-49, the base period, the fact that medical care prices had advanced relatively slowly during the previous decade is likely to be ignored. Moreover, comparison of the medical care index with the all-items index or with the indexes for the major groups conceals the fact that the movement of

medical care prices has been similar to that for other services combined."

COSTS OF SERVICES COMPARED

Her phrase "had almost regained," a general observation, is stated in terms of 1956 index numbers in the paragraph above—208 for commodities versus 194 for all items, and 185 for services versus 194.

In order to emphasize changes in various service prices, the same author lists the following percentage increases between 1936 and 1956: hospital room rates, 265 per cent; men's haircuts, 221 per cent; shoe repairs, 135 per cent; movie admissions, 114 per cent; public transportation, 113 per cent; laundry service, 108 per cent; automobile repairs, 84 per cent; dentists' fees, 82 per cent; general practitioners' fees; 73 per cent; surgeons' fees, 60 per cent.

THE MEDICAL CARE INDEXES

For 1956 the group of indexes classified as medical care and drugs (mostly services) stood at 184, or approximately 10 points below the entire Consumer Price Index on the long-time basis. On the other hand, on the basis of inflation since 1949 the index for medical care and drugs stood at 132.6, or 16 points above the entire Consumer Price Index. Thus, in the long-run period of inflation, the 1956 index of medical care and drugs was 10 points below the Consumer Price Index but 16 points above for the short-run period since 1949. So in the area of medical care and drugs the long-time lag in service prices is still evident.

The Bureau of Medical Economic Research of the American Medical Association has prepared a publication which presents these and other breakdowns of the indexes on both the 1935-1939 and the 1947-1949 base periods.[2] In the remainder of this review of inflation and medical care, comparisons will be confined to the long-run period because this inflationary period began in 1940 and not in 1949, as most adults know. Most monthly press releases on changes in the Consumer Price Index stress the changes since 1949 and present only one index for the entire medical care field.

SUBINDEX ITEMS

In relating medical prices to inflation, comparisons of some of the subindexes under medical care and drugs with the entire Consumer Price Index of 194.3 in 1956 have somewhat more significance to the members of the medical profession.

The indexes of physicians' fees included in the sample developed by the U. S. Bureau of Labor Statistics were below that of the Consumer Price Index for 1956 with the single exception of the fee for an "obstetric case." This particular index stood at 218.1 in 1956, or 24 points above the entire Consumer Price Index. There has been an enormous increase in the number of births, the actual increase since 1945 being from 2,700,000 to 4,100,000. From a strictly supply and demand standpoint, one would expect a higher rise in such fees than in other medical fees generally. Moreover, there are some who contend that medical fees for an obstetric case were at an unusually depressed level before World War II when the birth rate was very low and the obstetric case package contained fewer prenatal services. Whatever the explanations may be, the index for fees for an obstetric case stands out as the only exception to the general rule that the indexes for physicians' fees in 1956 were below the entire Consumer Price Index. The 1956 index for general practitioners' fees was 172.6; for an office visit, 172.6; for a house visit, 160.9; for an appendectomy, 155.0; and for a tonsillectomy, 164.9.

HOSPITALS AND MORE BABIES

The greatest change in the medical care field, however, has come in the index of hospital room rates, which stood at 356 for 1956. During this long period of inflation hospitals have been unusually exposed to the inflationary forces, particularly in the matter of wages and salaries. Moreover, the change from an average of one employee per patient to two employees per patient has harried many administrators of our voluntary hospitals. Both the quality and quantity of hospital services have changed considerably since 1940.

The indexes of dentists' fees, like those for physicians' fees, have also stayed well under the level of the Consumer Price Index. Our conclusion regarding the movement of prices in the medical care field is that these prices, to the extent indicated by the indexes, have behaved rather favorably for consumers, with the two exceptions noted. (Preliminary estimates of the medical care subindexes for midyear 1957 suggest that the 1956 relationship between them and the Consumer Price Index continues. Also, the index of service prices is still lagging behind the index for all commodities.)

INFLATION AND OTHER EXPENSES

In the third place, the influence of inflation is also manifested in the expenditures which consumers make for medical care and for all other items. According to the United States Department of Commerce personal consumption expenditures during 1956 for medical care totaled $12,106,000,000. In both 1955 and 1956 the total expenditures classified as those for hospital services exceeded those for services of physicians; the amounts for 1956 were $3,451,000,000 for hospitals and $3,269,000,000 for physicians' services. Again it must be stressed that the great increase in the number of births and the upward trend in the proportion of all babies born in hospitals has been a very powerful factor in increasing expenditures for both services.

The members of the medical profession do not need to be reminded that pregnancy is not a

disease. Reproduction does involve medical care expenditures, but it is obvious that increases in such expenditures do not indicate a deterioration in the health of the American people. The same government source also reports considerably greater 1956 expenditures for recreation than for all forms of medical care and considerably higher expenditures for such items as alcoholic beverages or tobacco than for either physicians' services or hospital services. In fact, even the expenditures for personal care exceeded those for hospital services.

LESS OF EACH DOLLAR PAID PHYSICIANS

Even more meaningful than dollars of expenditure are the percentages of personal consumer expenditures devoted to these different items. The 1956 percentage for all medical care items was 4.5 as compared with 4.4 per cent in 1955. The actual proportion for physicians' services alone was 1.2 in both years, whereas there was an increase from 1.2 to 1.3 per cent for hospital services. Within the medical care field these expenditures can be better compared by treating the total expenditures for all medical care as 100 cents, the medical care dollar. The proportion of the medical care dollar being paid to physicians has declined steadily from 1929,when it was 32.7 cents, to 27.2 cents in 1955 and 27.0 cents in 1956. On the other hand, the proportion of the medical care dollar spent for hospital services has climbed rapidly from 13.7 cents in 1929 to 27.7 cents in 1955, and to 28.5 cents in 1956. Likewise, the dentists' share has steadily declined over this same interval of time.

So the general conclusion as regards the proportion of the so-called consumer budget going for medical care is that the hospitals' share has been steadily rising until it was actually the largest share in both 1955 and 1956 and the physicians' share and the dentists' share have been steadily declining. During this period of time, medical progress has occurred at an exceedingly rapid rate and the improvements in the care of patients could scarcely have been achieved without some increase in the proportion of the consumer's dollar going for hospital services.

WAGE SHARE FOR MEDICAL CARE

For employees of industrial establishments who think in terms of weekly wages this story of the relationship of inflation to medical care can be presented in still another manner, the fourth comparison. Suppose that a physician's fee for a dozen office visits or a dozen house visits would have cost an entire week's wages before World War II. The important question to the wage earner is whether the same amount of medical service would cost more than a week's wages today or less than a week's wages. For physicians' fees the answer for 1956 is 48 per cent of a week's wages and 61 per cent for an obstetric case. The same number of days in a hospital which would have cost a full week's wages in 1935 to 1939 would have cost 99 per cent of a week's wages in 1956. Since such comparisons do not make allowances for the great increase in taxation, particularly in the taxes deducted from the weekly pay envelope, the standard of comparison here might be considered on a basis of the entire Consumer Price Index—say, a "market basket" containing the proper number of units of each of the items which are priced in the development of the Consumer Price Index. That standard of comparison for 1956 was 54 rather than 100 per cent, and those items which required more than 54 per cent of a week's wages may be considered as having been less favorable in the cost to the consumer.

PHYSICIANS' INCOMES

Turning now to the physician rather than the patient for the fifth comparison, we find that according to the U. S. Department of Commerce the average level of physicians' incomes in the United States was 122 per cent higher in 1951 than in 1929. The average level of incomes of all gainfully employed was 125 per cent higher. Thus during a much longer period of time the incomes of physicians and the incomes of all gainfully employed people have moved up at about the same pace. The United States Department of Commerce does not regard the studies it made of the incomes of physicians immediately before World War II as sufficiently detailed and comprehensive to provide a standard of comparison with the present levels. But that agency has made estimates for the years since 1951 and these, like the data for 1929 and 1951, show that this trend is continuing.

Other and more detailed comparisons could be made, but these five historical comparisons of the extent of inflation in the medical care sector of our national economy indicate that this sector has performed reasonably well for the consumer. Many citizens are becoming worried about the extent of inflation. As citizens, physicians should not be content to rest on their oars but should participate in discussions in their communities on ways and means to stem this dangerous inflationary tide.

Some community leaders are already suggesting buyers' strikes like those of 1919; others are urging local groups to petition the federal government to curtail spending. But if these and other attempts fail and inflation continues, it behooves the members of the medical profession to continue their efforts to moderate the ravages of inflation in the medical care sector.

REFERENCES

1. Langford, E. A.: Medical Care in the Consumer Price Index, 1936-56, Monthly Labor Review 80:1053-1058, September, 1957.

2. Medical Care Expenditures and Prices, 1955, Miscellaneous Publication M-106B, Bureau of Medical Economic Research, American Medical Association, Chicago, 1956.

Ohio Is Well Represented at Conference Of Physicians and Schools

Ten Ohioans attended the Sixth National Conference on Physicians and Schools at Highland Park, Illinois, October 30 to November 2. The conference is sponsored biennially by the American Medical Association and its Bureau of Health Education.

Approximately 225 physicians, public health officials, educators, and representatives of related organizations participated in the discussions, which were this year directed to the subject of youth fitness and how it can best be achieved.

As in past conferences, the meeting was set up around four general sessions, a conference dinner, and a conference banquet. The majority of the work of the conference was accomplished by the ten discussion groups, each of which dealt with assignments connected with the general theme, as listed below:

The Physician and Youth Fitness;
Community Coordination for Youth Fitness;
Mental-Emotional Aspects of Fitness;
Dramatizing Basic Fitness Procedures;
Medical Guidance in Girls' Physical Recreation Activities;
Special Health Problems in Athletics;
Fitness of School Personnel;
Optimum Fitness for Youth With Special Health Problems;
Accident Prevention and Youth Fitness;
Food Factors in Fitness.

Detailed proceedings of the conference will be available after the discussion group reports have been edited.

Dr. Charles H. McMullen, of Loudonville, was to have officially represented the Committee on School Health of the Ohio State Medical Association and was scheduled to speak at the second general session. He was unable to attend due to illness, and this responsibility was assigned to Committee Secretary Hart F. Page. Mr. Page also served as recorder to the group studying the theme "The Physician and Youth Fitness."

Charles W. Edgar, Jr., administrative assistant of the OSMA edited the report of a subcommittee of the group which dealt with special health problems in athletics.

Others attending from Ohio were P. C. Bechtel, Ohio Department of Education; Dr. A. O. DeWeese, Kent State University; Florence L. Fogle, R. N., Ohio State University; Dr. Margot D. Hartmann, Ohio Department of Health; Helen Massengale, Ohio Department of Health; Delbert Oberteuffer, Ohio State University; Elena M. Sliepcevich, D. P. E., Ohio State University; and William K. Streit, Cincinnati Board of Education.

Dr. Ella G. Lupton, 95-year-old Gallipolis Physician, is chairman of the Christmas Seal Sales for Gallia County Tuberculosis and Health Association, an organization she founded in 1928.

Resolutions Regarding Death of Dr. George P. Swan

The following resolutions regarding the death of Dr. George P. Swan, Cambridge, former Councilor of the Eighth District, have been adopted by the Guernsey County Medical Society, having been compiled and submitted by a committee consisting of Dr. C. A. Craig, James A. Toland and J. W. Camp:

"Dr. George F. Swan was born Sept. 10, 1889, near Boden in Knox Twp., Guernsey County, O., the son of Mr. and Mrs. Thomas K. Swan, and died suddenly on Sept. 26, 1957.

"WHEREAS: Dr. George Swan, as the eldest son of God-fearing parents whose place of leadership in their rural neighborhood was indisputable, had an inborn sense of family and community responsibility. He early chose medicine and surgery as his career and set about securing an adequate education through his own efforts. Later, having attained that goal, he not only set an outstanding example of excellence scholastically and professionally, but unselfishly lent a hand to younger brothers and nephews following in his footsteps, as a result of which five doctors in all now have become servants to humanity.

"Dr. Swan's sense of responsibility also was evidenced in his service record in World War I, during which his time was devoted to surgery in the Navy Medical Corps. Opening his practice in Cambridge in 1919, he exerted an ever-widening circle of influence within the city, county and state throughout his lifetime. Fully appreciative of the merits of education, he had in recent years given unstintingly of his time and talents to Muskingum College. The city of Cambridge also profited from his participation in community ventures, many of which came to fruition as the direct result of his interest and financial backing.

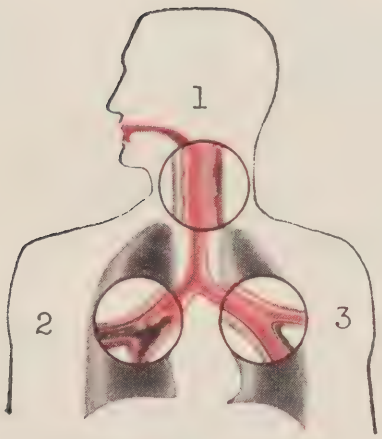
"As a medical doctor and skilled surgeon whose understanding of human frailties from both real and imaginary sources was especially keen, Dr. Swan set unusually high standards of gentlemanliness, ethics, sympathy and kindness in doctor-patient relationships, and his ability to point a moral through use of humorous anecdotes was a characteristic which will be long-remembered by his friends. Professionally, his counsel and advice within the medical organization were invaluable.

"THEREFORE BE IT RESOLVED by the members of the Guernsey County Medical Society that Dr. Swan was a cherished friend and respected colleague, in whose passing they share with his wife, Virginia McCarty Swan, his sister, brother, nieces and nephews, a sense of deep personal loss and profound regret, and they extend their heartfelt sympathy.

"FURTHER BE IT RESOLVED that a copy of these resolutions be spread on the minutes of the proceedings of the Guernsey County Medical Society, with additional copies to his wife, his brother, Dr. Raymond Swan, his sister, Mrs. Della McCall, and to the *Ohio State Medical Journal* for publication therein."

The Ohio Division of the American Cancer Society named Dr. Arthur G. James, Columbus, president. He was formerly vice-president. Dr. James is associate professor in the OSU Department of Surgery and Oncology, director of the Columbus Cancer Clinic and chairman of the OSMA Committee on Cancer.

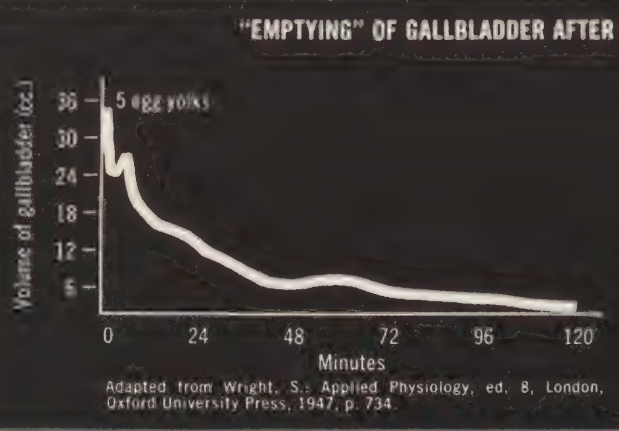
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Source—Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 1177.

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Mar. 17. Vaginal Approach to Pelvic Surgery, one week, Mar. 10. General & Surgical Obstetrics, two weeks, Feb. 24.

MEDICINE—General Review Course, two weeks, May 12. Electrocardiography & Heart Disease, two weeks, Mar. 17 Gastroscopy & Gastroenterology, two weeks, Mar. 3. Hematology, one week, June 2. Gastroenterology, two weeks, Apr. 14.

PEDIATRICS—Two-Week Intensive Course, April 21.

DERMATOLOGY—Clinical & Didactic Course, two weeks, May 5.

RADIOLOGY—Diagnostic X-Ray, two weeks, Mar. 3. Clinical Uses of Radioisotopes, two weeks, May 5.

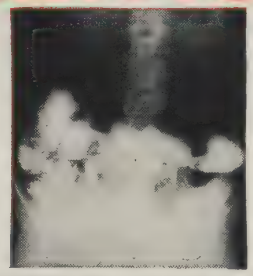
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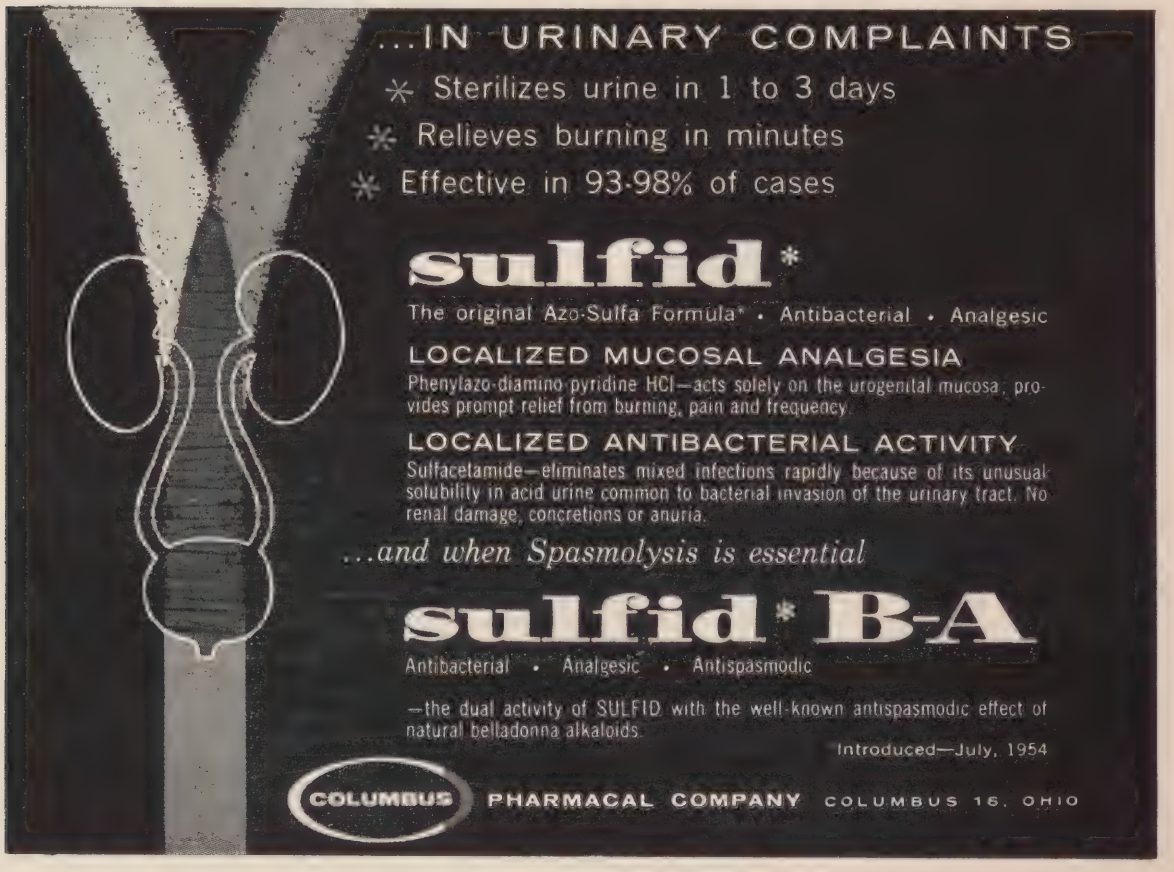
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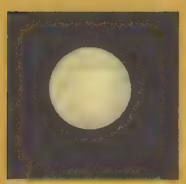
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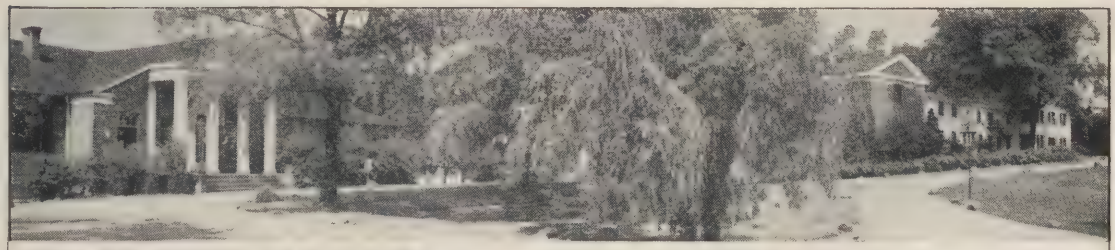
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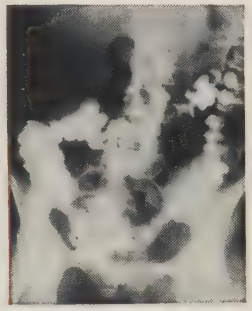
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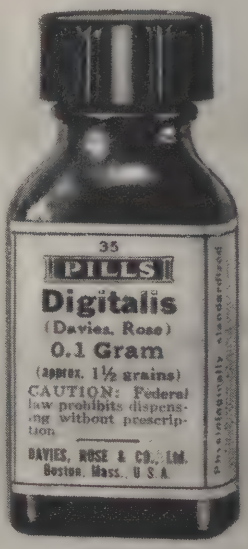
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Ohio Academy of History of Medicine Will Be Held in Cincinnati

The Ohio Academy of the History of Medicine will be held at the Taft Museum, Cincinnati, Saturday, April 26. Luncheon will be served at the University Club. Requests for presentation of papers at this meeting should be sent to Dr. Leon Goldman, and applications for exhibition of historical material should be sent to Dr. Robert H. Preston, both in the Carew Tower, Cincinnati.

At the time of this meeting, the annual Spring Exhibit of the Ohio Historical and Philosophical Society will be displayed at the Taft Museum. In addition, there will be an exhibit of selected materials from the David Tucker Library of History of Medicine at the College of Medicine.

New Executive Secretary of Ohio State Nurses' Association Assumes Duties

New executive secretary of the Ohio State Nurses Association is Miss Dorothy A. Cornelius, R. N., who has recently been assistant director of the Cleveland Regional Blood Center of the American Red Cross. Headquarters of the 11,000-member organization is at 904 E. Broad Street in Columbus.

Miss Cornelius is a graduate of Conemaugh Valley Memorial Hospital, Johnstown, Pa., has a B. S. degree in nursing education from the University of Pittsburgh and has done graduate work at the University of Pittsburgh.

For the past eight years she has been with the American Red Cross, formerly as chief nurse for the Johnstown, Pa., Regional Blood Center. She accepted transfer to the Cleveland center in March, 1952, and in November of the same year was promoted to assistant director, and became the only nurse in the country to hold a similar position.

During World War II, Miss Cornelius served with the Navy Nurses' Corps in the grade of lieutenant junior grade.

As executive secretary, Miss Cornelius succeeds Miss Celia Cranz, R. N., who retired to reside on the family farm in the Akron area after serving in that post since 1954.

A seminar on "Pathology of the Male Perineal Organs," was presented by the Southwestern Ohio Society of General Physicians at the Sheraton-Gibson Hotel, Cincinnati on November 24.

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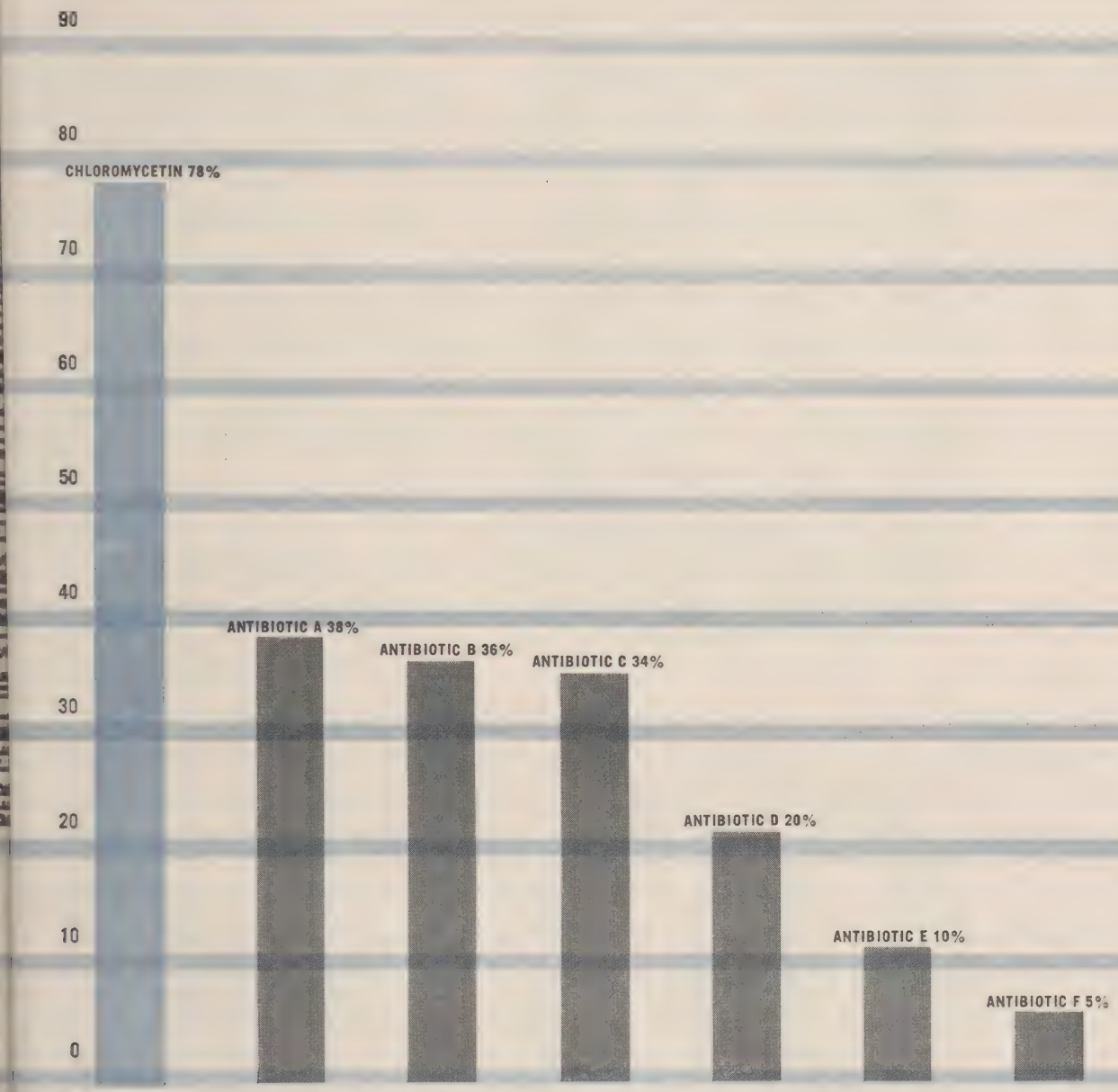
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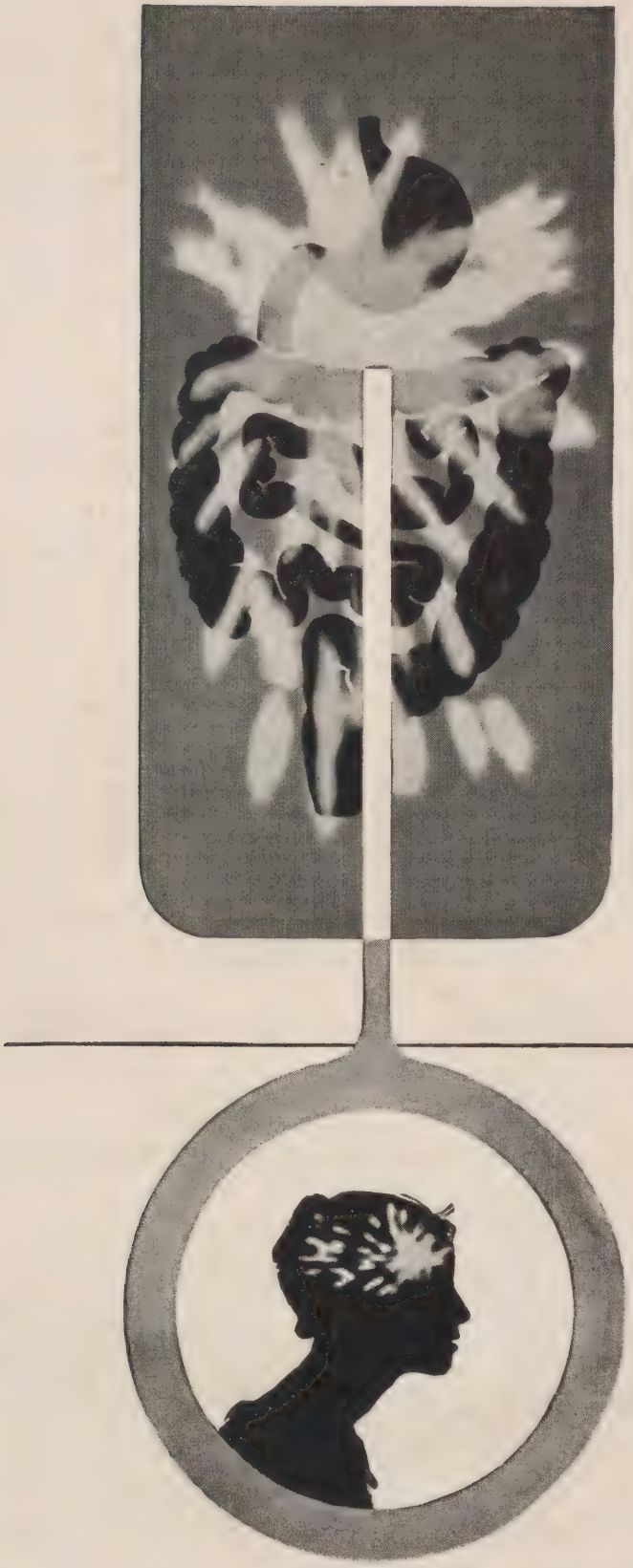
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The Ohio State Medical Journal

Vol. 54 February, 1958 No. 2

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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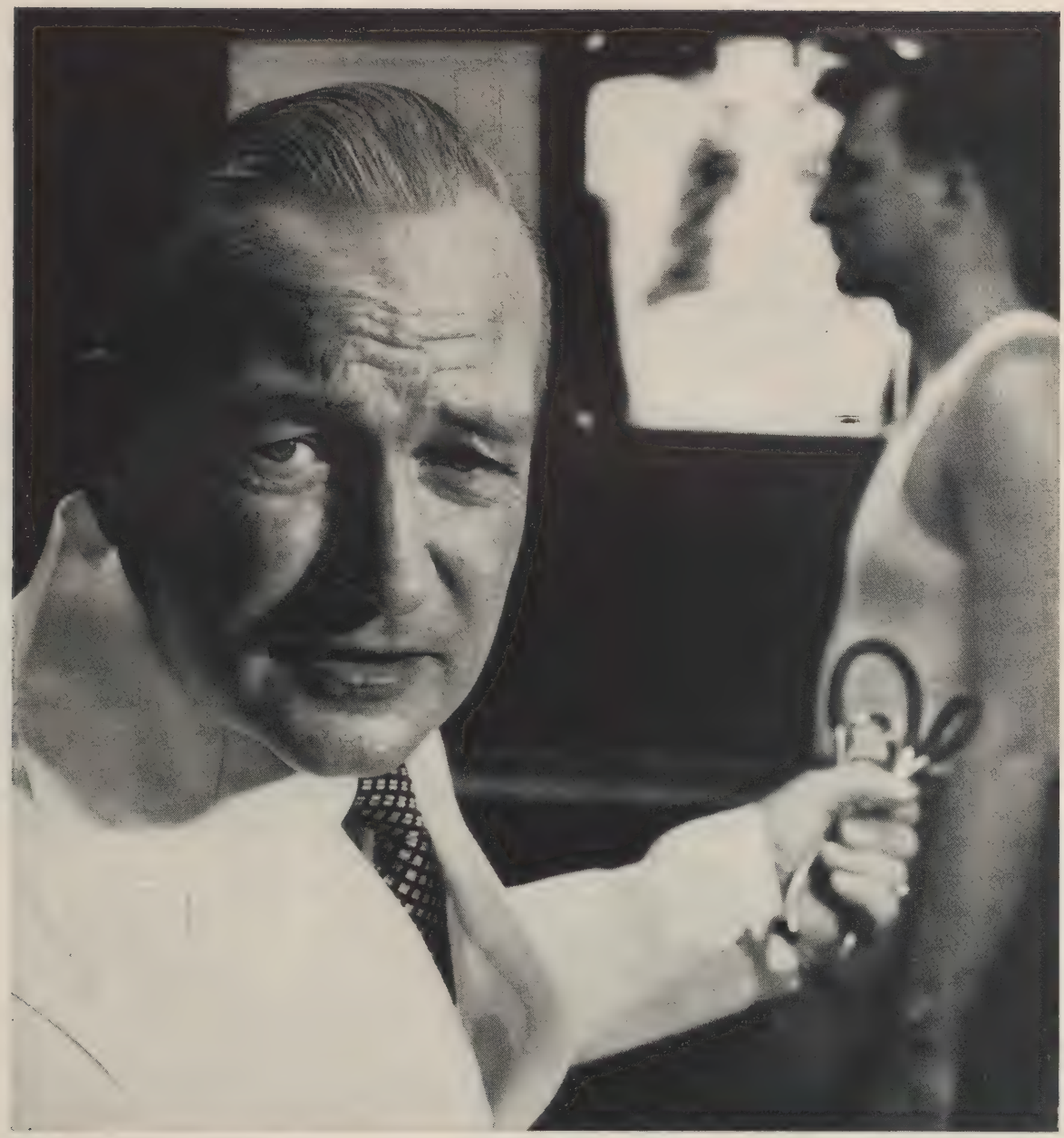
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Committee on Rural Health (1957-1958)—Edmond K. Yantes, Wilmington, Chairman; L. E. Anderson, Greentown; J. Martin Byers, Greenfield; E. G. Caskey, Mineral Ridge; Jonathan Forman, Dublin; V. R. Frederick, Urbana; Carl F. Goll, Steubenville; L. W. High, Millersburg; H. R. Mayberry, Bryan; Carll S. Mundy, Toledo; W. L. Murphy, Cardington; Robert E. Reiheld, Orrville; G. N. Spears, Ironton; H. K. Van Buren, Carey; Kenneth Taylor, Pickerington; D. S. Williams, Marietta.

Committee on School Health (1957-1958)—Thomas E. Shaffer, Columbus, Chairman; Charlotte Ames, Xenia; Elizabeth Rowland-Aplin, Columbus; Margaret E. Belt, Lima; Richard R. Buchanan, Wilmington; Walter Felson, Greenfield; Walter F. Heine, Circleville; Howard H. Hopwood, Jr., Cleveland; Dale A. Hudson, Piqua; Charles L. Kagay, Dayton; Robert A. Lyon, Cincinnati; Charles H. McMullen, Loudonville; Margaret O'Neal, Zanesville; J. M. Painter, Kent; Carl L. Petersilge, Newark; Robert C. Markey, Bowling Green; William S. Rothe, Bowling Green; Richard H. Schaefers, Wapakoneta; J. I. Rhiel, Port Clinton; H. B. Thomas, Gallipolis; J. W. Wilce, Columbus; Carl A. Wilzbach, Board of Health, City Hall, Cincinnati.

Woman's Auxiliary Advisory Committee (1957-1958)—James R. Jarvis, Van Wert, Chairman; Carl A. Gustafson, Youngstown; C. L. Pitcher, Portsmouth.

DELEGATES AND ALTERNATES

Delegates and Alternates to the American Medical Association—Paul A. Davis, Akron; Edmond K. Yantes, Wilmington, alternate; Charles L. Hudson, Cleveland; C. E. Hufford, Toledo, alternate; Carl A. Lincke, Carrollton; H. M. Platter, Columbus, alternate; Carll S. Mundy, Toledo; Paul F. Orr, Perrysburg, alternate; L. Howard Schriver, Cincinnati; E. O. Swartz, Cincinnati, alternate; C. C. Sherburne, Columbus; Richard L. Meiling, Columbus, alternate; George A. Woodhouse, Pleasant Hill; R. Dean Dooley, Dayton, alternate; Herbert B. Wright, Cleveland; Fred W. Dixon, Cleveland, alternate.

County Societies' Officers and Meeting Dates

FIRST DISTRICT

ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—John R. Donohoo, President, Georgetown; Leslie Hampton, Jr., Secretary, Sardinia. 1st Sunday, monthly.

BUTLER—John R. Perkins, President, Middletown; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Last Wednesday of alternate months.

CLERMONT—Richard D. Carr, President, Williamsburg; Harry M. Breuer, Secretary, New Richmond. Third Wednesday, monthly.

CLINTON—Roy D. Goodwin, President, Wilmington; H. Richard Bath, Secretary, Wilmington. 2nd Tuesday, monthly.

HAMILTON—George X. Schwemlein, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 152 East 4th Street, Cincinnati. 2nd Tuesday, monthly.

HIGHLAND—Glenn B. Doan, President, Greenfield; Kenneth Lyle Upp, Secretary, Greenfield. 1st Friday, monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

SECOND DISTRICT

CHAMPAIGN—John K. Pond, President, Urbana; William Pudvan, Secretary, Mechanicsburg. 2nd Wednesday, monthly.

CLARK—John D. LeFevre, President, Springfield; Charles E. Fralick, Secretary, Springfield. 3rd Monday, monthly.

DARKE—V. Ray Boli, President, Greenville; Emmett W. Arnold, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Joseph R. Schauer, President, Fairborn; Norman G. Linton, Secretary, Jamestown. 2nd Thursday, monthly.

MIAMI—Deane B. Armour, President, Bradford; Dale A. Hudson, Secretary, Piqua. 1st Friday, monthly, except June and July.

MONTGOMERY—Albert V. Black, President, Centerville; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton. 1st Friday, Jan., Feb., March, April, May and November; 1st Wednesday, June, October and December.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. Annual meeting only.

SHELBY—James W. Tirey, President, Anna; Robert H. Lanfersieck, Secretary, Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Walter E. Yingling, President, Lima; Thomas D. Allison, Secretary, Lima, 3rd Tuesday, monthly, except June, July and August.

AUGLAIZE—Robert J. Herman, President, Wapakoneta; Robert S. Oyer, Secretary, Wapakoneta.

CRAWFORD—Charles J. Griebling, President, Galion; James E. Loggins, Secretary, Galion. 3rd Friday, monthly.

HANCOCK—Frank M. Wiseley, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Richard A. Dietrich, President, LaRue; Wm. F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOGAN—Frederick W. Kaylor, President, Bellefontaine; Charles A. Browning, Jr., Secretary, Bellefontaine. 1st Friday, monthly.

MARION—Daniel M. Murphy, President, Marion; James A. Schuler, Secretary, Marion. 1st Tuesday, monthly, except June, July, August.

MERCER—Robert M. Fell, President, Celina; Julius Schwieger, Secretary, Fort Recovery. 3rd Thursday, monthly.

SENECA—Harry P. Ulicny, President, Fostoria; Emmet T. Sheeran, Secretary, Fostoria. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

FOURTH DISTRICT

DEFIANCE—John F. Holtzmuller, President, Defiance; George L. Boomer, Secretary, Defiance. 1st Saturday.

FULTON—Edwin R. Murbach, President, Archbold; Robert A. Ebersole, Secretary, Archbold. 4th Tuesday, monthly.

HENRY—Tony P. Delventhal, President, Napoleon; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday, monthly.

LUCAS—Max T. Schnitker, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; Robert W. Minick, Secretary, Oak Harbor. 2nd Thursday, monthly.

PAULDING—T. P. Fast, President, Grover Hill; John H. Schaefer, Secretary, Paulding.

PUTNAM—James B. Overmier, President, Leipsic; Will W. Moody, Secretary, Vaughnsville. 1st Tuesday, except June, July and August.

SANDUSKY—Karl K. Grubaugh, President, Woodville; R. Allen Eyestone, Secretary, Gibsonburg. 3rd Wednesday, monthly, except June, July and August.

WILLIAMS—Robert A. Gilreath, President, Bryan; Robert W. Dilworth, Secretary, Montpelier. 3rd Tues., monthly.

WOOD—J. Victor Pilliod, President, Grand Rapids; Richard L. Pearse, Secretary, Bowling Green. 3rd Thurs., monthly.

FIFTH DISTRICT

ASHTABULA—Harold C. Franley, President, Jefferson; Arthur B. Shaul, Secretary, Ashtabula. 2nd Tuesday.

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Executive Office, 2009 Adelbert Road, Cleveland. 2nd Tuesday, monthly.

County Societies' Officers and Meeting Dates (Continued)

GEAUGA—Walter C. Corey, President, Chardon; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—David Danenberg, President, Bridgeport; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vorhies, Secretary, Scio. Meetings quarterly.

JEFFERSON—Warren G. Snyder, President, Wintersville; Frances J. Shaffer, Secretary, Toronto. 2nd Tuesday.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Don R. Johnson, President, Nelsonville; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—George F. Jones, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—William B. Faircloth, President, Zanesville; William A. Knapp, Secretary, Zanesville. 1st Tuesday.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Deane H. Northrup, President, Marietta; Joseph E. LaBarre, Secretary, Marietta. 2nd Wednes., monthly.

NINTH DISTRICT

GALLIA—Ralph B. Burner, President, Gallipolis; George E. Files, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Cecil L. Grumbles, President, Waverly; Benton V. D. Scott, Secretary, Waverly. 1st Tuesday, monthly.

SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. 1st Monday after the 1st Tuesday.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Mary K. Kuhn, President, Ashley; Edward C. Jenkins, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Frank C. King, President, Washington C. H.; H. Wm. Payton, Secretary, Jeffersonville. 2nd Tuesday.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mt. Vernon; Clinton W. Trott, Secretary, Mt. Vernon. 1st Thursday.

MADISON—Ernest S. Crouch, President, London; Robert S. Postle, Secretary, London. 1st Wednesday, monthly.

MORROW—Joseph P. Ingmire, President, Mt. Gilead; Lowell Murphy, Secretary, Cardington. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Charles H. McMullen, President, Loudonville; William H. Rower, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—Owen J. Nicholson, President, Norwalk; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Harry Wain, President, Mansfield; Riley E. Frush, Secretary, Mansfield. 3rd Thursday, monthly.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Physician's Federal Income Tax Guide, 1958 Edition, by Hugh Campbell and James B. Liberman, edited by Henry D. Shereff. ($2.50. *Channel Press, 159 Northern Boulevard, Great Neck, New York.)* The twelfth annual edition of a valuable tax guide that is extremely useful to practicing physicians is available from the publishers; also in leading bookstores.

Tuberculosis in Obstetrics and Gynecology, by George Schaefer, M. D. ($8.75. *Little Brown and Co., Boston 6, Mass.)* The book is based on an experience of over 17 years with tuberculosis at two large tuberculosis hospitals as well as two large general hospitals. The author is currently in charge of the Pulmonary Clinic at the New York Lying-in Hospital.

Gynecologic Nursing, by R. J. Crossen, M. D., and Ann Jones Campbell, R. N. ($4.25. Fifth edition. *C. V. Mosby Co., St. Louis 3, Mo.)* This book continues on the same plan of previous editions and brings up to date the details of diagnosis, treatment and nursing care.

Neurosurgical Alleviation of Parkinsonism, by Irving S. Cooper, M. D. ($8.50. *Charles C. Thomas, Springfield, Ill.)* The purpose of this book is to summarize the present status of this form of treatment.

A New Psychotherapy in Schizophrenia, by Marguerite Sechehaye. ($4.50. *Grune and Stratton, New York, N. Y.)* This plan purposes to relieve frustation by symbolic realization.

Lysergic Acid Diethylamide and Mescaline in Experimental Psychiatry, by Louis Cholden, M. D. ($3.00. *Grune and Stratton, New York, N. Y.)* Proceedings of a round table held at the annual meeting of the American Psychiatry Association.

Physique and Delinquency, by Sheldon and Eleanor Glueck. ($6.00. *Harper and Brothers, New York 16, N. Y.)* From probably the foremost authorities on delinquency today comes this report on their latest investigation in delinquent behavior. The findings indicate that there is significant relationship between body types and types of behavior.

Anxiety and Magic Thinking, by Charles Odier, M. D. ($5.00. *International Universities Press, New York 11, N. Y.)* Represents one of the first attempts at an integration of psychoanalytic concepts with the findings of Piaget's genetic psychology.

Diseases of the Nose, Throat and Ear, by I. Simson Hall. ($4.75. Sixth edition. *E. & S. Livingstone Ltd., Edinburgh;* U. S. distributors, *Williams and Wilkins, Baltimore, Md.)* The book remains the same in size as it has in the previous editions and lives up to the same standards as being an excellent manual.

Polysaccharides in Biology, edited by Georg F. Springer, M. D. ($5.00. *Josiah Macy, Jr. Foundation, P. O. Box 575, Packanack, N. J.)* It is a transaction of the first Macy conferences on this subject. It deals with Nomenclature, Classification, Bacterial Polysaccharides and Blood groups.

Neuropharmacology, edited by Harold A. Abramson, M. D. ($4.25. *Josiah Macy, Jr. Foundation, P. O. Box 575, Packanack, N. J.)* Second conference on this subject in which a long list of distinguished scientists participated including Dr. Chauncey Leake of Ohio State University.

Mankind Against the Killers, by James Hemming. ($3.50. *Longmans, Green & Co., New York 3, N. Y.)* It tells with gripping simplicity the story of man's striving to understand and master pestilential diseases.

Cosmetics; Their Principles and Practices, by Ralph G. Harry. ($17.00. *Chemical Publishing Co., Inc., 212 Fifth Avenue, New York 10, N. Y.)* Extensive developments in the cosmetic and toilet industry in the past 10 years have made it necessary for a completely new work. In this volume we have an all-embracing work which now becomes the bible of all who are interested in the subject.

Educating Spastic Children, by F. Eleanor Schonell, Ph. D. ($6.00. *Philosophical Library, 15 E. 40th St., New York 16, N. Y.)* This book is designed to provide first-hand information of an educational and psychological kind for all concerned with the education, upbringing, and general welfare of the cerebral palsied.

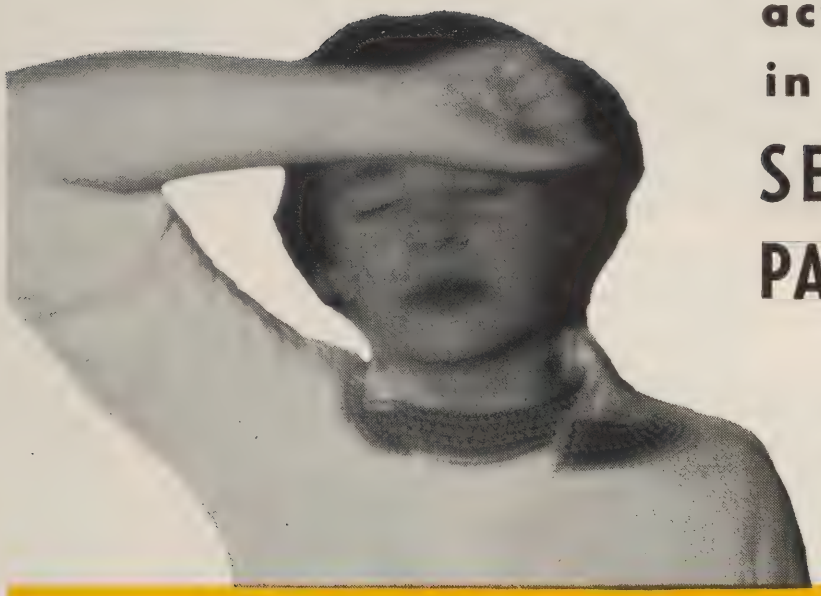
Venous Return, by Gerhard A. Brecher, M. D., Ph. D. ($6.75. *Grune & Stratton, Inc., New York 16, N. Y.)* The Julius F. Stone Professor of Physiology in the Ohio State University has given us a comprehensive account of his work with a proper historical setting. Dr. Carl J. Wiggers says in his foreword "the volume of blood returned to the heart is the basic determinant of cardiac output."

Aging: A Current Appraisal, edited by I. L. Weber. ($2.50. *University of Florida Press, Gainesville, Florida.)* A report on the Sixth Annual Southern Conference on Gerontology held at the University consisting of 44 essays by well-known authorities.

Care of Long-Term Patient. Chronic Illness in the United States—Volume II, by Commission on Chronic Illness. ($8.50. *A Commonwealth Fund Book, Harvard University Press, Cambridge, Massachusetts.)* This volume is based to a con-

(Continued on Page 140)

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*Joseph, Morris: Effective Analgesia Without Sedation or Narcosis, Clinical Medicine, August 1957.

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siderable extent upon the material of the National Conference of the Long-Term Patient held in Chicago in 1954, but is not limited to a discussion of the conference material drawing freely on additional sources.

William's Obstetrics, by N. J. Eastman, M. D. ($14.00, Eleventh Edition. *Appleton-Century-Crofts, New York 1, N. Y.)* This well-received text represents the teaching and tradition of Johns Hopkins School of Medicine.

Organized Home Medical Care in New York City. ($8.00. *A Commonwealth Fund Book, Harvard University Press, Cambridge, Mass.)* A study of 19 programs by the Hospital Council of Greater New York.

The Nature of Brucellosis, by Wesley W. Spink, M. D. ($8.00, *University of Minnesota Press, Minneapolis 14, Minn.)* A world authority on Brucellosis presents a comprehensive and current review of animal and human forms of the disease and the results of research and experimentation.

Rosenau's Preventive Medicine and Public Health, by K. F. Maxcy, M. D. ($15.00, Eighth edition. *Appleton-Century Crofts Inc., New York 1, New York.)* With aid of 27 specialists, the Professor Emeritus of Epidemiology brings up to date the eighth edition of this text which has been standard since 1913.

Handbook of Pediatric Medical Emergencies, by Adolph G. DeSanctis, M. D., with 11 contributors. ($6.25, second edition, *C. V. Mosby, St. Louis 3, Mo.)* This is an authoritative manual which has been translated into Spanish, Turkish and Yiddish. New emphasis is placed on accidents and poisoning, metabolic emergencies, and the complications of poliomyelitis.

New Advances in Medicine and What They Mean to You, by Morris Fishbein, M. D. ($3.50, *Hanover House, Garden City, N. Y.)* This book attempts to bring the layman up to date just as the author has done for the medical profession with his volume **Medical Progress.**

Dictionary of Poisons, by Ibert and Eleanor Mellan. ($4.75, *Philosophical Library, Inc., New York 16, N. Y.)* Designed to assist in emergency. Done in simple, concise language, if kept handy can help to prevent many of the 34,000 annual deaths in the American home.

The Approach to Mental Health, by David T. Maclay, M. D. ($3.00, *Associated Booksellers, 2106 Post Road, Westport, Conn.)* A psychiatrist presents a book for the educated layman describing the various factors that contribute to normal mentality.

Vital Statistics of the United States: 1954 Vol. II. ($4.00, *U. S. Government Printing Office, Washington 25, D. C.)* This volume gives the mortality data for the United States and each separate state and is to be used with Volume I which describes the sources and limitations of the data.

Principles of Clinical Electrocardiography, by Mervin J. Goldman, M. D. ($4.50, *Lange Medical Publications, Los Altos, California.)* The cardiologist to Oakland V. A. Hospital presents the basic concepts and their clinical application.

The Drug Addict as a Patient, by Marie Nyswander, M. D. ($4.50, *Grune and Stratton, New York 16, N. Y.)* The president of the National Advisory Council on Narcotics deals in this book not only with the disease but with the addict as a person—his psychological makeup and the impact of his environment.

Medical Ethics, by Edwin F. Healy, S. J. ($6.00. *Loyola University Press, Chicago 13, Ill.)* Illustrated by 171 case histories goes much further into the problem of treatment, professional ideals, professional secrecies, truthfulness, and unethical procedures.

Comparative Anatomy of the Eye, by Jack H. Prince of the Ohio State University. ($8.50. *Charles C. Thomas, Springfield, Ill.)* Correlates sufficient information to enable courses on this subject to be prepared easily for Veterinary, Ophthalmological, and Optometrical students.

Year Book of Pediatrics: 1956-57, edited by Sydney S. Gellis, M. D. ($6.75, *Year Book Publishers, Chicago 11, N. Y.)* The high points of the attractive and authoritative review are the declining rate of retrolental fibroplasia, increased resistance to antibiotics of staphylococci, danger of radiation and man-made diseases.

Safety Education, by A. E. Florio, Ed. D., and G. T. Stafford, Ed. D. ($5.50, *McGraw-Hill Book Co., New York 36, N. Y.)* The inclusion of safety education has rapidly become a requirement in most states. This text is designed to prepare teachers for this course.

Pharmacology and Oral Therapeutics, by Edward C. Dobbs, D. D. S. ($9.00, eleventh edition, *C. V. Mosby, St. Louis 3, Mo.)* The introduction of many new drugs has prompted another edition of the well known and widely used text.

Health Observation of School Children, by George M. Wheatley, M. D., and Grace T. Hallock. ($6.50, second edition. *McGraw-Hill Book Co., New York 36, N. Y.)* A guide for helping teachers and others to observe and understand the school child in health and disease.

Medical Effects of the Atomic Bomb in Japan, edited by A. W. Oughterson, M. D., and Shields Warren, M. D. ($7.50, *McGraw-Hill Book Co., New York 36, N. Y.)* This is one of a series prepared as a record of the studies done under the Manhattan Project and the Atomic Energy Commission. Its contents will be of increasing importance to all of us.

Home Health Emergencies, (Apply. *Medical Department, The Equitable Life Assurance Society of the United States, 393 7th Ave., New York 1, New York.)* It is a guide to home nursing and first aid in family health emergencies.

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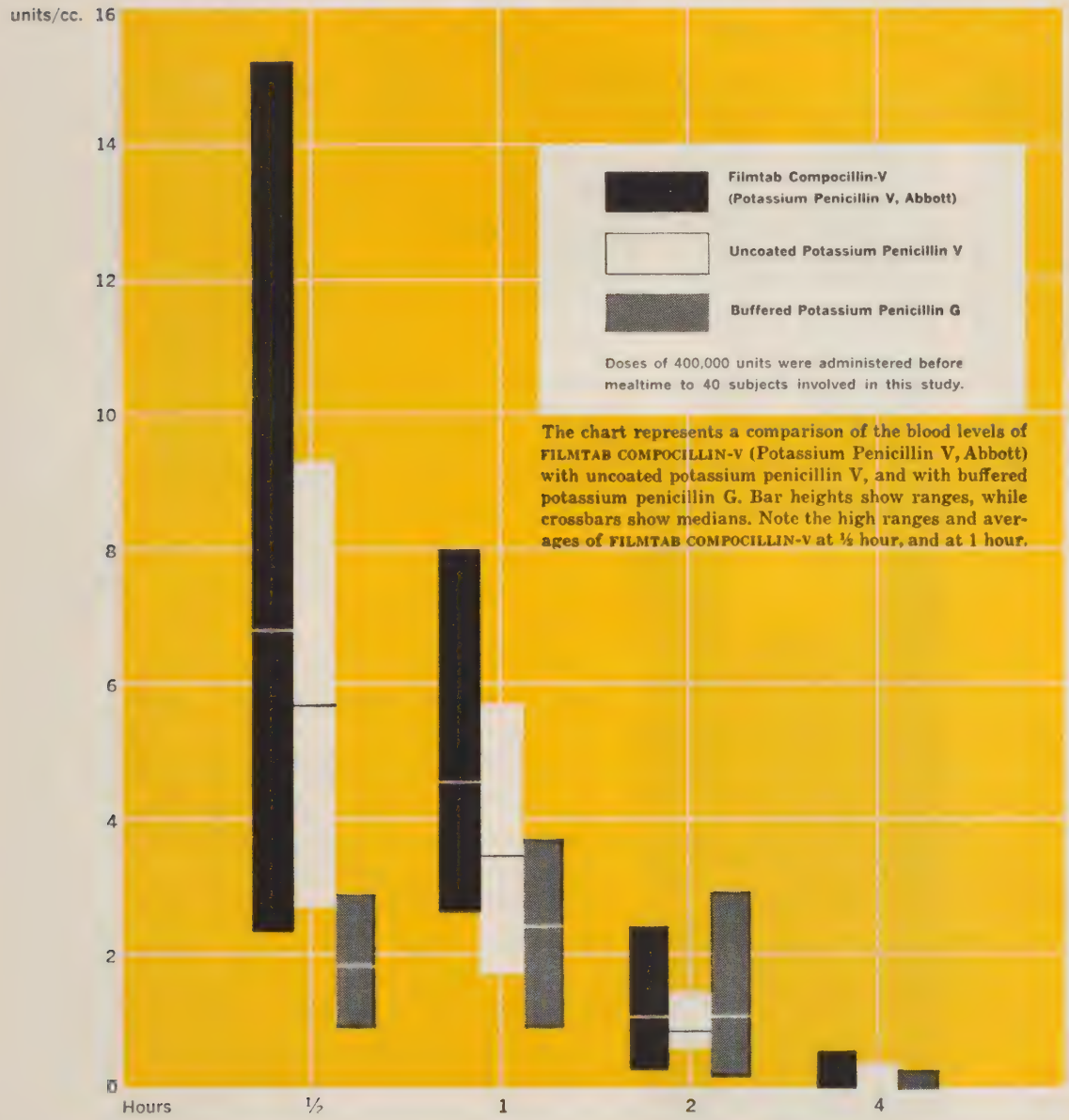
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Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

THE HIGHER BLOOD LEVELS OF COMPOCILLIN-V
—IN EASY-TO-SWALLOW FILMTABS AND TASTY, ORAL SUSPENSION



Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

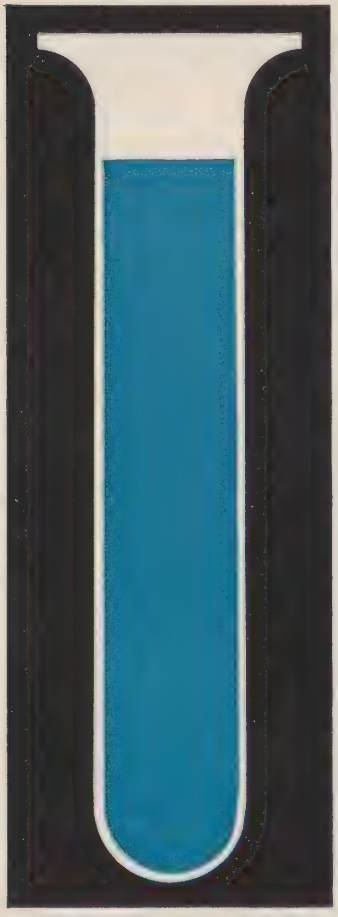
COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed – stays stable for at least 18 months.

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Spontin®

(Ristocetin, Abbott)

and when coccal infections hospitalize the patient



Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

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A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED



SPONTIN comes to the medical profession with a clinical history of dramatic results — cases where the patients were given little chance of survival.

During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

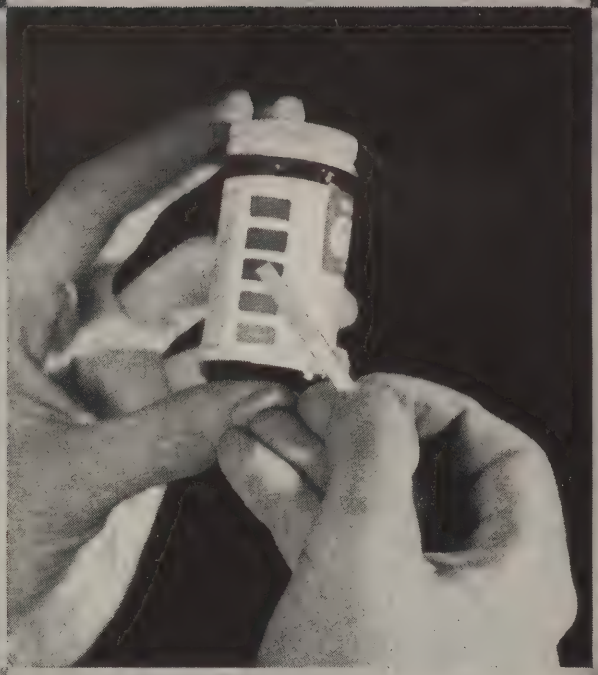
1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity — no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare — and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients — does your hospital have it stocked?

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does proteinuria occur more frequently in any type of heart failure—myocardial hypertrophy, mitral valve, coronary artery, aortic valve or hypertensive heart disease?

No. The incidence of proteinuria is about equal among the various types of cardiac patients in failure.

Source—Race, G. A.; Scheifley, C. H., and Edwards, J. E.: Circulation *13*:329, 1956.

first colorimetric test for proteinuria

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"...alseroxylon is an antihypertensive agent of equal therapeutic efficacy to reserpine in the treatment of hypertension, but with significantly less toxicity."

Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.



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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Medical care consumer price index hit 140.3 in November, maintaining its continued increase. Bureau of Labor Statistics reported increase due to higher hospital, counter drugs and prescription rates.

* * *

Survey of 8,000 hospitals to gain information concerning progressive care—or graded service—is being conducted by Public Health Service. Under graded plan, amount of patient care provided is determined by seriousness of patient's illness.

* * *

Pentagon has reported that 2,016 interns have applied for commissions. This means that, barring national emergency, armed forces may not have to invoke physician draft for at least 18 months.

* * *

National Clearinghouse for Poison Control Centers has completed and sent to 115 local centers a card file of trade names of 500 household products that could be dangerous if misused. Toxic ingredients, symptomatology and antidotes are described.

* * *

Lashing out at public's "bovine tolerance" of conditions resulting in disability from chronic diseases and accidents, Surgeon General Burney in an address said that on August 1, 1957, it was estimated that 41 per cent of the entire U. S. population had one or more "chronic conditions."

* * *

Insect physiologists of the Agriculture Department have found the common house fly is potentially valuable as a test organism for rapid screening of tumor-inhibiting compounds. Researchers reported affirmative results of studies to find anti-cancer compounds that act as inhibitors of ovarian growth in female flies. Fifteen of 26 chemical substances gave positive results.

* * *

National Institute of Neurological Diseases and Blindness is administering special travel fund to help "younger ophthalmologists" and paramedical professionals engaged in ophthalmological teaching and research. Successful applicants will have expenses paid for 18th International Ophthalmological Congress in Brussels September 8-12. Applicants should write Dr. Gordon H. Seger, chief, extramural programs, National Institute of ND and B, Bethesda 14, Md. April 1 is application deadline.

* * *

Health, Education and Welfare Undersecretary John A. Perkins has proposed total re-examination of welfare programs, in light of heavy Federal spending for defense research and science. "I am suggesting that the present state of world affairs is a signal that there inevitably will be a review on all levels of government of all governmental services," he told American Public Welfare Association.

* * *

AFL-CIO Committee on Social Security has set up plans for opposing medical societies that refuse to endorse union medical programs, and has asked the AFL-CIO Executive Committee for funds to finance promotion of union medical programs.

* * *

By end of 1957, according to Health Insurance Institute estimates, more than 123 million Americans were protected by some form of health insurance designed to help pay hospital, doctor or other medical care bills. Figure represents almost 75 per cent of the total U. S. civilian population.

Baltimore Social Security Office Is in Need of Physicians

The following announcement is from Dr. Arthur B. Price, chief medical consultant for the Federal Division of Disability Operations:

The Bureau of Old-Age and Survivors Insurance, Social Security Administration, has announced vacancies for full-time and part-time medical consultants in its Division of Disability Operations. The Division is responsible for making determinations of disability under the disability insurance provisions of the Social Security Act. These positions are available in the headquarters offices in Baltimore, Maryland.

Physicians interested in either full-time or part-time positions may write to Dr. Arthur B. Price, Chief Medical Consultant, Division of Disability Operations, 200 West Baltimore Street, Baltimore 1, Maryland, for further information.

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Prescribe Bifran tablets for your overweight patients.

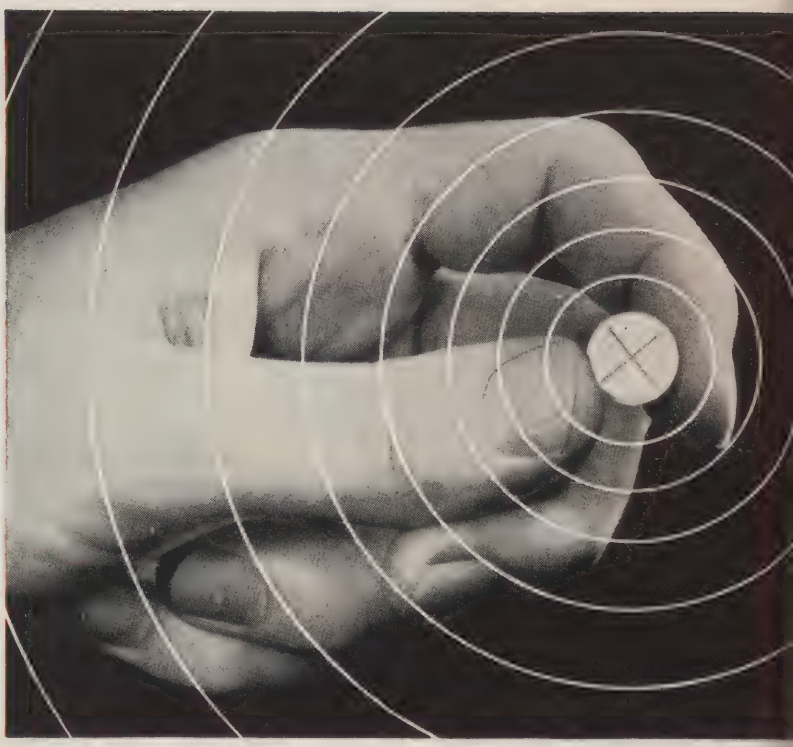
Each Bifran tablet contains 5 mg. methamphetamine hydrochloride, 200 mg. dehydrocholic acid (Maltbie), and 15 mg. pentobarbital.

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New authoritative studies show that KYNEX dosage can be reduced even further than that recommended earlier.[1] Now, clinical evidence has established that a single (0.5 Gm.) tablet maintains therapeutic blood levels extending beyond 24 hours. Still more proof that KYNEX stands alone in sulfa performance—

- Lowest Oral Dose In Sulfa History—0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
- Higher Solubility—effective blood concentrations within an hour or two
- Effective Antibacterial Range—exceptional effectiveness in urinary tract infections
- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE

The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

Tablets:
Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup:
Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

"PACKAGED PATIENTS," A PR REVIEW OF '57; SUGGESTIONS FOR '58

In the January issue of the *Newsletter* of the California Medical Association there appeared the above headline. It was over a most revealing and stimulating article—one which, in our opinion, is so good that it would be a shame not to give Ohio physicians a chance to absorb it. Therefore, with apologies, credits, and all those things to the *California Newsletter,* we present herewith the article, written by Sidney J. Shipman, M. D., chairman, Public Relations Committee of the California Medical Association:

* * *

"Patients, the medical profession found in 1957, continue to come to physicians' offices in a growing variety of packages.

"The 'large economy size' contained patients with varied insurance coverages, many of them with unrealistic fee schedules.

"The 'trial package' or get-acquainted-offer, included 450,000 elderly patients who, on October 1, began coming to see physicians for limited services on the wave of California's Public Assistance Medical Care Program. They came from 'Medicare' labeled for 'Govt. Use Only.'

Panels, Too

"The 'standard pack' continues to be represented by Blue Shield members who receive their medical care under a program sponsored and controlled by the physicians. And then there are the 'limited pack' panel patients.

"Nationwide, these patients, along with their 'third parties,' the insurance companies, the labor administrators and the consultants, accounted for four billion and 200 millions of the total medical care bill. *In California alone, packaged patients are a million-dollar-per-day item!*

"The tremendous upsurge received its greatest impetus in 'fringe benefits in lieu of wage increases.'

"Should the current clamor for more and better education in the fields of science extend into the realm of basic economics and hammer home 'there ain't no Santa Claus' facts of life, we could expect changes. But we don't!

"Regardless of the package they come in, physicians, by and large, have an excellent performance record of taking care of *all* patients.

"At all times CMA has maintained the policy, as expressed by President Frank A. MacDonald, that 'what may appear advantageous to the individual physician is not always to the interest of the entire profession, while what is good for the profession, is good for each individual practitioner.'

United Approach

"The past year's experience in dealing with third parties has demonstrated the value of a united approach—the approach for the 'entire profession.'

"In the year ahead it is of the utmost importance that this policy be strengthened.

"Medicine's policy, its determination to maintain high medical standards, can only be furthered when it is understood.

"To be understood requires untiring effort and patience; time consuming conferences with the third party purchasers of medical care who seek 'freedom of choice' for their groups.

"Meanwhile, only the individual practitioner can make this commodity—freedom—the most desired of all ingredients—regardless of all other parts in the insurance package!

"As the 'old master,' the very politically conscious Dr. Dwight H. Murray, has said:

> *" 'Satisfied patients always have been, and always will be, our first line of defense against government domination of our profession.'*

"To be sure, in the light of an increasing number of medical packages, he might well have said '*all* third party domination.'

"The *individual* physician has shown his ability to make his patients appreciate his skills and his personal interest in them.

The 'Other' Physician

"It is the 'other physician' who must be reminded to do his utmost to maintain satisfied patients; patients who will demand continued service from him even though a third party has intervened for the prepayment of this care.

"It is the collective physician, the County Medical Society, that must guarantee high quality medical care regardless of inability to pay, to provide for emergency medical care 'round the clock. And, to prevent the misunderstandings which may develop

into malpractice suits, it behooves the County Societies to make certain their Public Service Committees are active and ready to make forthright decisions when disputes arise. These things are basic. These are the every day requirements to make all patients—the collective patient—satisfied patients.

Constantly!

"We repeat what we've said before: the road to good public relations is direct. The entrance is posted with the sign: 'Be A Good Doctor.' We might juggle a participle and add: 'Constantly.'

"So much for the professional side . . .

"1958, as was '57, will be marked with more 'entering wedges for government medicine,' more Santa Claus schemes, more third party packages.

"In '57 we found that, while the opposition arguments of medical leaders were sound, too few physicians backed this position with communications to legislators. Even more disconcerting, all too few physicians took time to find out about issues involving their own profession. The results were about as to be expected.

"It follows, therefore, that, in this limited discussion, progress for the profession and the protection of the welfare of the patient, demands that each physician must also be aware of the political and economic aspects of medicine; to make an intelligent appraisal of all medical 'packages.' To be alert—constantly!"

OHIO YOUNGSTERS NEED FAMILY PHYSICIANS, TOO

It is somewhat startling to sit in a state 4-H health committee meeting and hear an extension agent remark that "80 per cent of the 4-H club members in my county do not have a family physician." That happened here in Ohio recently.

The agent stated that this condition was brought out as a result of 4-H club health activities. The specific activities involved are encouraged by OSMA through its Committee on Rural Health. They are the 4-H physical examination and the personal health record.

The 4-H boys and girls were at a loss as to where to get an examination when they were handed the forms and health records. Undoubtedly, this pointed up to them the importance of having a family physician. However, one cannot help but wonder what the percentage is in Ohio's other 87 counties.

It is difficult to believe that the youngster who has no family physician is fulfilling all of his health needs. Not enough can be said for proper diet, adequate sleep and other good physical and mental health habits. Apparently, not nearly enough has been said for the necessity of having a family physician.

In our opinion, it would be an excellent project and an outstanding community and medical service for a county medical society to survey its teenage and pre-teen population to determine how many have family physicians; perhaps better, to determine those who do not— and why they don't —have a family physician. It would not be inconsiderate to expect the cooperation of school officials and youth leaders in such a worthwhile venture.

Total of 6,700 Foreign Physicians Study in United States

More than 6,700 foreign physicians were taking advanced medical training in American hospitals in 1956-57, a survey conducted by the Institute of International Education and the AMA reveals.

The study covered only interns and residents who had both a foreign citizenship and permanent residence in a foreign country. It did not include displaced persons resettled in the U. S. or foreign citizens who have immigrated to the U. S. for permanent residence.

There were 6,741 foreign physicians serving internships or residencies in 797 American hospitals. Of these physicians, who came from 88 countries, 4,753 were residents and 1,988 were interns. Only 908 of the total were women and more than 60 per cent of these women were from the Far East.

The physicians were in 44 states, the District of Columbia, Hawaii, and Puerto Rico. Four states, Idaho, Nevada, New Hampshire, and Wyoming, did not report any. About one fourth (1,673) of all the foreign doctors were in New York state. More than 100 each were in Ohio, Illinois, Massachusetts, Pennsylvania, New Jersey, Missouri, Maryland, Michigan, Texas, the District of Columbia, Connecticut, and Minnesota.

Over one third (2,293) came from the Far Eastern countries with Latin America and Europe each the origin of one fifth, and the Near and Middle East of one eighth.

The foreign residents were studying in 31 different specialties, with general surgery and general medicine leading the list.

Ft. Steuben Academy

"Modern Cardiac Surgery," was the topic of discussion at the January 14 meeting of the Fort Steuben Academy of Medicine, Steubenville. Speakers were Dr. Donald B. Effler, chief of the Department of Thoracic Surgery, Cleveland Clinic; and Dr. Howard H. Minor, a member of the surgical staff at the Ohio Valley Hospital, Steubenville.

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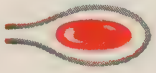
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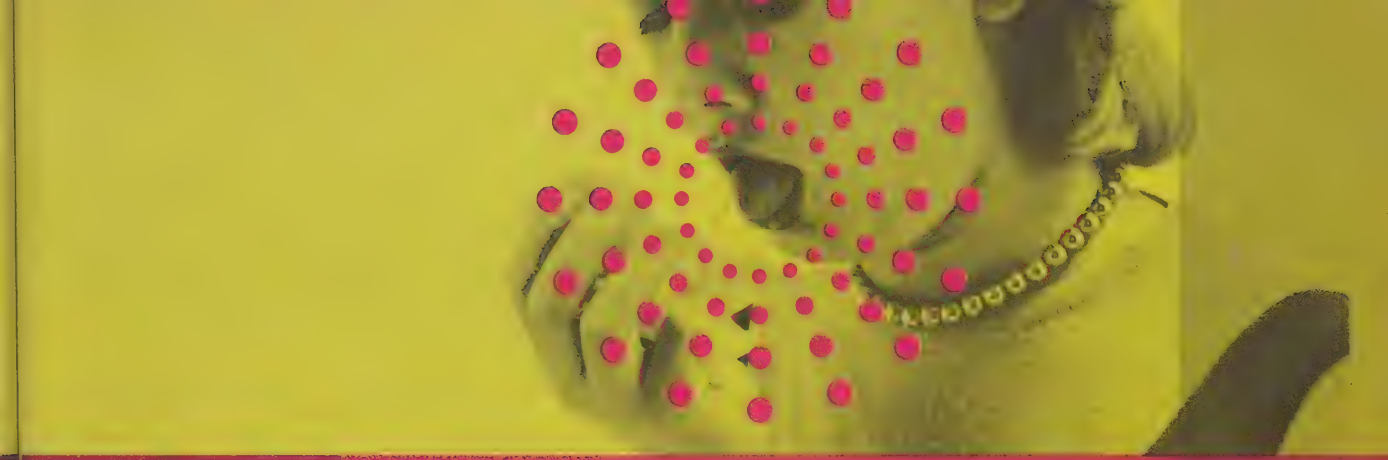
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monitors the cough *and* the cold in children and adults

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Salicylamide	0.19 Gm.
Phenacetin	0.13 Gm.
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Ascorbic acid	50 mg.
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On Rx and cannot be refilled without your permission

dosage

One capsule every four to six hours.

packaging

Bottles of 100 and 1000.

CORICIDIN,® brand of analgesic-antipyretic.

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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

The Board of Trustees has announced the appointment of Mr. George Cooley as secretary of the A. M. A. Council on Medical Service. He took over the post left vacant on January 1 when Secretary Thomas A. Hendricks was moved into his new assignment as field director of the American Medical Association.

A graduate of the University of Cincinnati with degrees in political science and public administration, Mr. Cooley once served as secretary of the Cincinnati Regional Crime Commission. He also served as field consultant to the National Municipal League, and as executive secretary of the Academy of Medicine of Toledo and Lucas County before going with the AMA on a part-time basis in September 1945.

He goes into his new job with wide experience in council affairs. He has been serving as assistant secretary of the council since March 15, 1946.

Mr. Cooley, who is 46, was born in Mitchell, South Dakota, which he refers to as the "famous corn palace of the world." He and his wife, Mary, and their daughter, Marcia, 16, live in Park Ridge, a Chicago suburb where several other AMA staff people reside.

Aids State Department

Ralph Creer, AMA director of motion pictures and medical television, was one of 21 persons invited recently to a conference in Washington by the State Department to determine U. S. policy on participation in future international film festivals.

Science Writing Program

Columbia University's Graduate School of Journalism has announced establishment of an advanced science writing program to be financed by a pilot grant from the Alfred P. Sloan Foundation.

Under the program, selected young reporters and writers will be invited to spend an academic year at the university with all expenses paid. While only four to five full fellowships a year can be financed under the initial grant, it is hoped soon to expand the program to provide for 10 fellows a year. Medicine is represented on the advisory board which has been set up to handle the program.

Said Alfred P. Sloan: "Large scale scientific development depends, in the last analysis, on public understanding. This understanding, in turn, is possible only if scientific news is intelligently and fully reported. We are confident this program will be an important step in helping achieve this goal."

AMA General Manager

A realignment of executive duties at the American Medical Association went into effect January 1. Dr. George F. Lull took over the position of assistant to the president. Dr. F. J. L. Blasingame of Wharton, Texas, assumed responsibility for over-all administration with the title of general manager.

Dr. Blasingame has been active in medical affairs, both at the state and national levels, for many years. Since 1949, he has been a member of the AMA Board of Trustees, and in 1955 he served as president of the Texas State Medical Association.

In his new job, Dr. Lull will relieve the president of many of the burdens of that office in addition to serving as secretary of the Association. He will act as a special ambassador of the medical profession in cities and towns throughout the country. Dr. Lull joined the AMA staff in 1946 after serving 34 years in the Army. His last position before Army retirement was as deputy surgeon general.

Auxiliaries Vie in *Today's Health* Contest

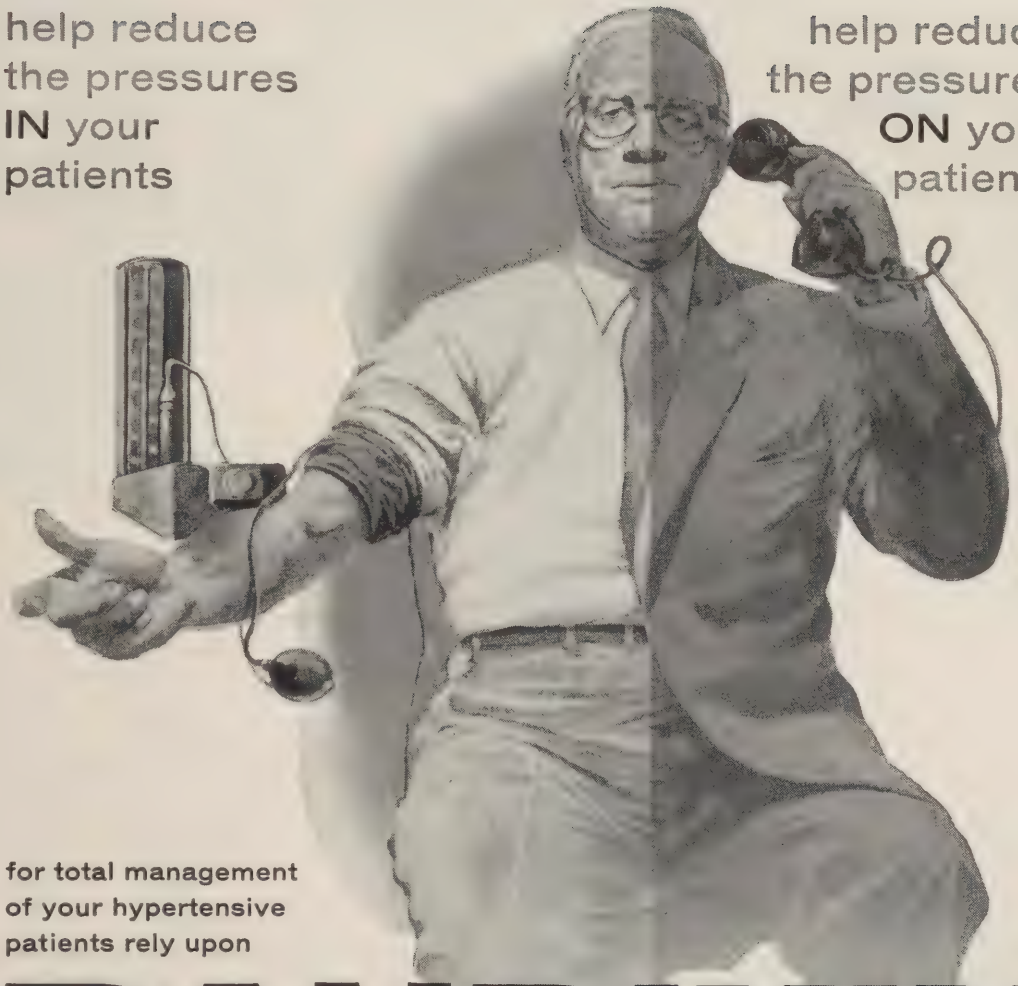
The annual *Today's Health* subscription contest for medical auxiliaries throughout the country again is under way. The contest—jointly sponsored by the Woman's Auxiliary to the AMA and *Today's Health* magazine—is open to all state and county auxiliaries.

Medical Practice Booklets

Additional copies of the booklet—"A Planning Guide for Establishing Medical Practice Units"—currently are available from the American Medical Association to state and county medical societies for use on a loan basis to individual physicians. Edited by the AMA and published through a Sears-Roebuck Foundation grant, this booklet originally was distributed to medical societies on a limited basis. However, if the copies now on file in medical society libraries have been mutilated or destroyed, requests for additional copies may now be filled. Requests should be directed to the AMA's Council on Medical Service.

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patients

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the pressures
ON your
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Raudixin provides gradual, sustained lowering of blood pressure in hypertensive patients, as well as a mild bradycardia. Hence, the work load of the heart is reduced.

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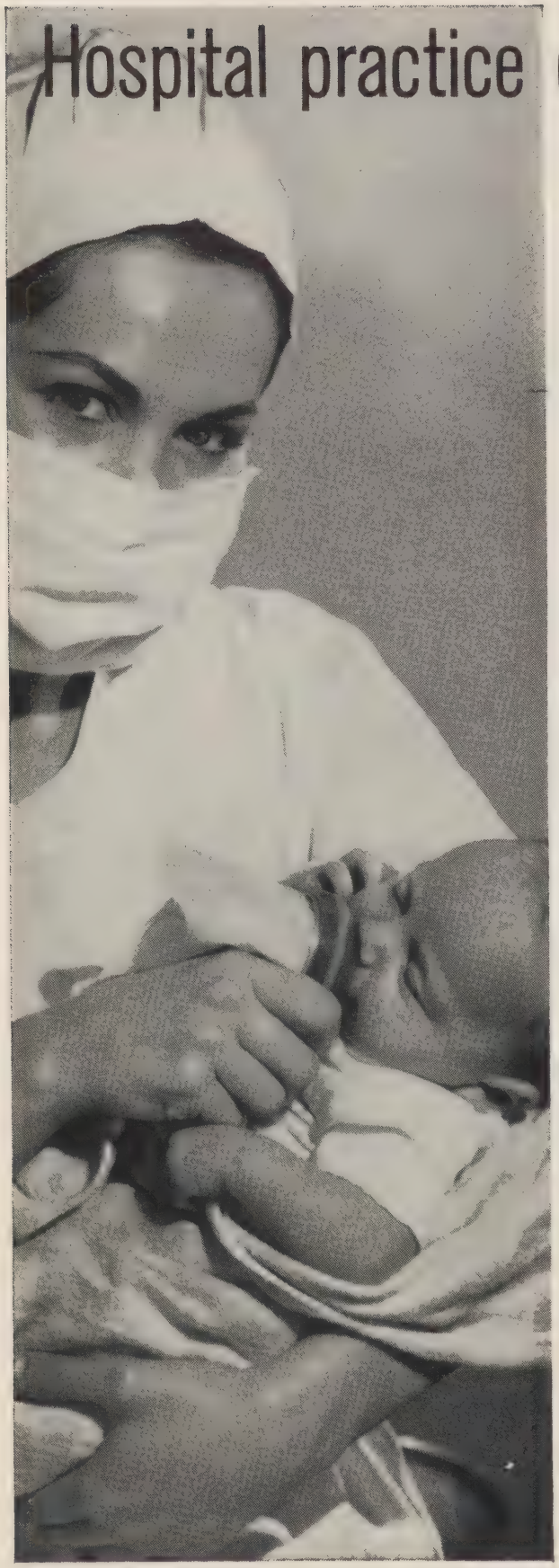
Corrin, K. M.: Am. Pract. & Dig. Treatment 8:721 (May) 1957.

Tranquilizing Raudixin helps relax the anxious hypertensive patient so that he is better able to cope with external pressures without being overwhelmed by them. By reducing these anxieties and tensions, Raudixin helps break the mental tension —hypertension cycle.

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The first feeding, 12 hours after birth, consists of a prelacteal solution of 5% Karo Syrup, one or two ounces, repeated at two-hour intervals. Breast feeding is started on the second day for five-minute intervals and the prelacteal feeding continued immediately thereafter and between nursings.

Formula feeding is given on the second day if breast feeding is denied. The small infant prefers the three-hour schedule and the large infant the four-hour schedule.

The initial formula is a low-caloric milk mixture, gradually increased in concentration over several day intervals according to tolerance. Standard formulas for whole cow's milk or evaporated milk modified with diluted Karo Syrup as shown here, constitute the dietary regimen for well newborns.

First formulas for newborns, concentrated according to tolerance

Evaporated Milk Formulas: 3 oz. q 4h x 6 feedings

	FORMULA I	FORMULA II	FORMULA III
	12.5 cals./oz.	16 cals./oz.	20 cals./oz.
Evap. Milk	4 oz.	5 oz.	6 oz.
Water	14 oz.	13 oz.	12 oz.
Karo Syrup	1/2 oz.	3/4 oz.	1 oz.

Whole Cow's Milk Formulas: 3 1/2 oz. q 4h x 6 feedings

	FORMULA I	FORMULA II	FORMULA III
	11 cals./oz.	11.5 cals./oz.	13.5 cals./oz.
Whole Milk	8 oz.	9 oz.	10 oz.
Water	12 oz.	11 oz.	10 oz.
Karo Syrup	1/2 oz.	3/4 oz.	1 oz.

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You and Your Public . . .

The Individual Physician Should Know and Understand Health Programs of Organizations in His Community

IT is an important public relations factor that the individual physician be familiar with health programs of various organizations represented in his community. There are in Ohio many such organizations in which personal health is an important part of their programs.

A member of an organization is surprised and pleased when his personal physician discusses with him a health project the patient's organization may be undertaking.

Also, the physician may help his patient to understand the project better, and to appreciate the importance of medical advice in any lay health program.

Health Interest High

For example, there are in Ohio two groups having health programs that offer the physician extensive public relations opportunities. The groups are the Ohio Congress of Parents and Teachers and the 4-H Clubs. Both have extensive health programs that include permanent health records for children that cover their first 18 years. Both are extensive in detail and cover the individual's health statistics thoroughly.

The P. T. A. record was developed within that organization, while the 4-H record was developed by the OSMA Committee on Rural Health and printed by OSMA for distribution through 4-H Club leaders.

Those two groups are representative of the organizations not primarily devoted to health, but, nevertheless, interested in health.

Lay groups welcome the interest and advice of physicians in their health programs. When this is lacking, there may be misunderstanding or misinterpretation of the program.

For example, a prominent youth organization's health program here in Ohio for its local clubs ran into some snags that clearly could have been avoided if there had been local liaison with physicians. A physician's explanation of the purpose of the program and discussion of its materials would have meant much to the club leaders.

This is not meant as a criticism of the organization or physicians, but is to illustrate an actual situation in which a good PR possibility was overlooked; in which constructive help could have been provided.

On the other hand, there is another organization in which the advice and cooperation of physicians eliminated a considerable gap in the organization's health policies. The PR results were very prominent at this group's 1956 state convention.

Too busy to do something like this? In 1952, retiring AMA President John W. Cline, M. D., said in his farewell address:

"Being 'too busy' is partly a state of mind. It also serves as an excuse to escape from doing something you do not wish to do."

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Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

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Extent of Voluntary Health Insurance Coverage in the United States. Annual survey of the Health Insurance Council, this booklet covers the five voluntary types of health insurance and gives the total number of Americans participating in each type. Write Health Insurance Council, 488 Madison Avenue, New York 22, N. Y.

* * *

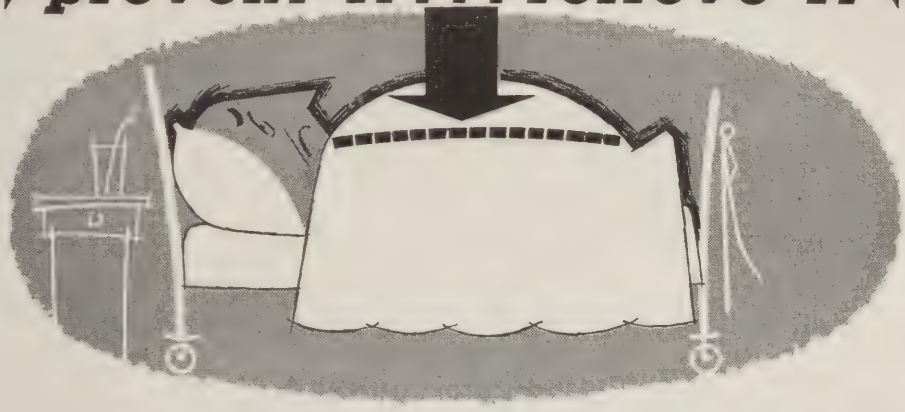
Steps for Today toward Better Mental Health. This report of the 1957 National Health Forum contains a digest of what was said by 102 program participants in 15 discussions and eight general sessions. ($1.50) Write National Health Council, Inc., 1790 Broadway, New York 19.

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Tips for Better Personal Public Relations. Lists 28 pertinent PR points for the practicing physician. Concise but complete in two pages. Write Broome County Medical Society, 42 Front Street, Binghamton, N. Y.

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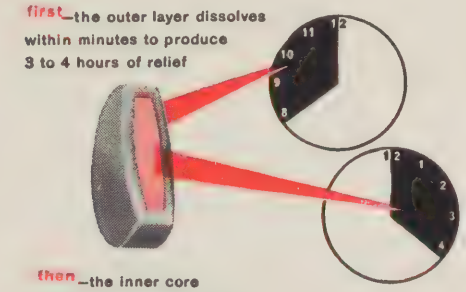
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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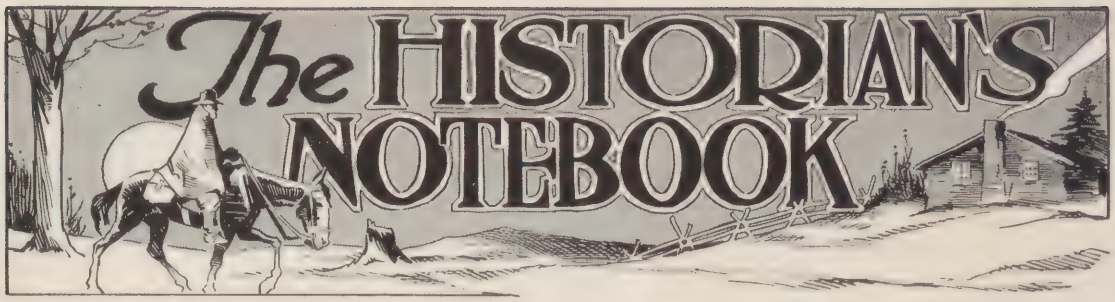
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Governor Cox and Public Health in Ohio.

ROBERT G. PATERSON, Ph. D.

PART 1

WITH the death of the Honorable James Middleton Cox in Dayton on Monday, July 15, 1957, Ohio lost a statesman of the first rank. He was born at Jacksonburg, Miami County, Ohio, March 31, 1870. He lived 87 years, long enough to witness the triumph of his losing espousal of the League of Nations in his presidential campaign of 1920 when the charter of the United Nations came into effect on October 24, 1945.

Governor Cox was a champion of tuberculosis and public health work in Ohio throughout his three terms—1913-15; 1917-19; 1919-21, as chief executive of the state. In his Autobiography, *Journey Through My Years*[1] published in 1946, there is no word of his activities in these fields of endeavor. The probable explanation for this omission was due to his belief that such matters were beyond political controversy and required no defense. It is because of the omission that the record should be supplemented here in The Historian's Notebook of the definite accomplishments of Governor Cox in the promotion of public health in Ohio.

Constitutional Convention, 1911-12

When I returned to Ohio on May 1, 1911, Ohio was seething with active discussion of proposals to be submitted to the forthcoming Constitutional Convention.[2] An Act of the General Assembly in 1911 provided for the election of a Convention by nonpartisan ballot. The Convention was to meet on the first Monday in January 1912. Ohio was governed by the Constitution adopted in 1851. It was a straight jacket modeled for a rural population. Between 1851 and 1911 Ohio rapidly became an industrial community and the people recognized the necessity for many fundamental changes in the basic law of the state. The need for reform permeated all sections of Ohio.

The Author

● **Dr. Paterson, retired and now living in Tryon, North Carolina, is Executive Secretary Emeritus 1911 - 1946; Director of Research 1946 - 1952, Ohio Tuberculosis and Health Association.**

My first major task was to undertake a statewide survey[3] of the facilities available for combatting tuberculosis. Naturally in my travels to various places in Ohio I was exposed to all the pet arguments for amendments to the state Constitution. I also heard rumblings from physicians and public health workers that all was not well in the affairs of the Ohio Board of Health.

Crisis in Ohio State Board Of Health, 1911

The political crisis in the Ohio State Board of Health came to a head when Charles O. Probst, M. D. (1857-1933) the Secretary of the Board, resigned on August 10, 1911, effective, September 30, 1911. He had been Secretary since July 28, 1886. Thus he served in this capacity for 25 years. Dr. Probst has left a delightfully informal and privately circulated account of his recollections and reminiscenses of his work.[4]

In April 1912, Dr. Probst attended the Sixty-seventh Annual Meeting of the Ohio State Medical Association at Dayton and read a paper entitled "Tuberculosis."[5] In this paper he advocated

the creation of a State Tuberculosis Commission[6] separate and apart from the state health authority. The Council of the Association endorsed his proposal.

On June 1, 1912, Eugene F. McCampbell, M. D. (1880-1937) assumed the duties of Secretary of the Ohio State Board of Health, taking over from Mr. James E. Bauman (1870-1950)[7] who had been appointed Acting Secretary on October 1, 1911. As Executive Secretary of the Ohio Society for the Prevention of Tuberculosis, I immediately placed before Dr. McCampbell the results of the tuberculosis survey I had made and the action taken by the Ohio State Medical Association on the proposal made by Dr. Probst at Dayton in April. I argued that since tuberculosis was a communicable as well as a preventable disease that the responsibility for the tuberculosis program should be lodged with the Ohio State Board of Health and not with a newly created State Tuberculosis Commission.

Action by OSMA Council, 1912

Dr. McCampbell agreed with my argument. Steps were taken to have called a special meeting of The Council of the Ohio State Medical Association in September to reconsider the action taken at Dayton. At this meeting Dr. Probst was present to urge The Council to hold firm to the decision taken by the Association. Dr. McCampbell and I appeared to advocate that the Ohio Board of Health be given responsibility for dealing with the tuberculosis problem. We based our argument upon the necessity for sound administration, economy and avoidance of confusion in the public mind. The Council reversed the decision of the Association and approved our proposal.

The Ohio Constitutional Convention composed of 119 delegates, finished its labors on June 6, 1912, after having been in session from January 9. As a result of its deliberations, out of 340 proposals debated, 42 amendments were proposed and were voted on in a special election held in September, 1912. Thirty-four of the 42 amendments were adopted. As Governor Cox has written, "these changes gave Ohio what was generally regarded as one of the most liberal of all state constitutions. Some of the changes were mandatory, some merely permissive—a fact which made the character of the next administration (which I was destined to head) of vital importance."[8]

Cox Nominated for Governor, 1912

In June, a State Democratic Convention met in Toledo and unanimously by acclamation nominated James M. Cox for Governor of the state. He was elected in November, 1912. Our problem was to devise ways to enlist the active interest and support of Governor Cox for our tuberculosis program. Through Robert H. Bishop, Jr., M. D. (1879-1955) of Cleveland, who was Executive Secretary of the Anti-Tuberculosis League of Cleveland, and much interested in the Ohio Society for the Prevention of Tuberculosis, an appointment was made with Mr. Cox through the good offices of the Honorable Newton D. Baker, (1871-1937) a leading Democrat in Cleveland and close political friend of Mr. Cox.

The appointment was made for me to see Governor Cox in December at the Neil House in Columbus. This was my first meeting with Governor Cox although I had heard him speak on several occasions. He listened attentively to my presentation, the crux of which was to ask for an appropriation by the Legislature of $25,000 annually for the biennium 1913-1915, for the establishment of a division of tuberculosis in the Ohio State Board of Health. Mr. Cox asked two or three pertinent questions and then said he would be willing to back the program, both in his message to the Legislature and in his budget request. The interview lasted no more than 15 minutes. Naturally from that day I have always had the greatest admiration for Governor Cox's ability to make prompt and firm decisions.

Parenthetically, the $25,000 requested meant an annual increase in the budget of the Ohio State Board of Health to $75,000 per annum. I recall that when the proposal was first discussed with Mr. Bauman, Acting Secretary of the State Board, his response was a skeptical disbelief that any such amount would be appropriated by the Legislature just for one disease. The pattern up to this time had been for the State Board to be content with small increases in its budget from biennium to biennium. In the 25 years the annual budget for the State Board had increased from $5,000 in 1886 to $50,000 in 1911.

(To Be Concluded in March Issue)

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1. Cox, James M.: Journey Through My Years. New York, Simon and Schuster, 1946.

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4. Probst, Charles O.: Recollections and Reminiscences of Public Service and Public Health Workers. Mimeographed, August 1930, pp. 33.

5. Probst, Charles O.: Tuberculosis. Ohio State M. J., **8**:279, May, 1912. (Read but not published.)

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7. Paterson, Robert G.: James E. Bauman's Service to the State of Ohio. Ohio State M. J., Vol. 46, March-April Nos. 3-4, pp. 249-252; 341-344, 1950.

8. Cox, James M.: Op. cit. p. 123.



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Vol. 54 February, 1958 No. 2

JONATHAN FORMAN, M. D., *Editor*

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Comitant Strabismus

HERMANN M. BURIAN, M. D.

INTRODUCTION

TO institute a rational treatment of comitant strabismus it must be understood that strabismus is a complex condition. In the etiology of a case of comitant strabismus various innervational and non-innervational factors are operative. It is essential to determine in the individual patient to what extent each of these factors contributes to the appearance of the strabismus, since the treatment will be greatly influenced by the preponderance of one or the other of them. How the nature of strabismus can best be determined is the first problem in the diagnosis of strabismus.

THE ETIOLOGIC DIAGNOSIS

History

It can be stated in a general way that the more variable the condition is, the more it is likely that it is produced predominantly by factors of an innervational nature. Here the taking of the history can already be of help to the experienced ophthalmologist. If the parents report that the child's squint is inconstant and present especially when the child is tired or excited, and that they have noted it first when the child was two to two and one-half years old, it is very likely that innervational, accommodative, factors play a decisive role. If the squint was present from infancy and has been more or less constant, non-innervational factors must be suspected.

From the Department of Ophthalmology, College of Medicine, State University of Iowa.

Presented before the Section on Ophthalmology at the Annual Meeting of the Ohio State Medical Association, Cleveland, Ohio, April 10, 1956.

The Author

● **Dr. Burian, Iowa City, Iowa, is Professor of Ophthalmology, College of Medicine, State University of Iowa.**

Refractive Error

The determination of the refractive error is an essential step in establishing the etiologic diagnosis. The finding of a hypermetropia of + 2.00 D to + 4.00 D is strong evidence, though not conclusive proof, of the presence of an accommodative factor. The hypermetropia may be coincidental and only a minor element in the etiology of a strabismus due primarily to other causes. In children past the pre-school age a hypermetropia of less than + 2.00 D may be significant. On the other hand, a hypermetropia of more than + 4.00 D may not cause an accommodative strabismus, since the child may prefer blurred vision to the effort required to overcome the hypermetropia by accommodation. The final evaluation of the importance of the refractive error and with it of the accommodative factor depends on the effect which its correction has on the condition. This will be further dealt with in discussing the optical correction of strabismus.

Angle of Squint

Constancy of the angle of squint—i.e. its independence from passage of time, condition of the patient and conditions of testing—indicates that

non-innervational factors play a significant role; inconstancy points to innervational factors.

The angle of squint should be measured for distance fixation (at least 6 m) and near fixation (33 cm) and while the patient wears glasses and is without them. Comparison of the four figures so obtained permits one to draw important conclusions. For example, if the angle of squint in an esotropic patient is larger for near than for distance fixation and if the glasses have a marked effect on the deviation, this allows one to classify the condition as being largely accommodative in nature. If the deviation, in an exotropic patient, is greater for near than for distance fixation, another innervational condition, a convergence insufficiency must be suspected. If, in any patient, the glasses have little effect on the deviation and if the angle of squint remains, in general, rather constant, other factors than these immediately apparent innervational factors are implicated. There exists then a *"basic"* esotropia or exotropia.

The deviation determined for distance fixation while the patient wears his glasses may be designated as the *static angle of squint,* whereas the deviation for near may be termed the *dynamic angle of squint.*

Although the etiologic diagnosis must be made before a patient is operated upon, the behavior of the deviation in deep anesthesia is of interest. A reduction or disappearance of the deviation under those circumstances is evidence for its innervational origin. If the deviation remains unchanged it is due to non-innervational causes.

Effect of Drugs

It must be expected that in the cases in which excessive accommodation has led to the deviation, the angle of squint will be altered when accommodation is influenced by pharmacologic means.

In many of these cases the installation of alkaloids of the atropine group which make it impossible for the patient to accommodate, results in a pronounced reduction of the angle of squint. However, this is not invariably true, even in typical cases of accommodative strabismus. In some instances, especially if the cycloplegia obtained is not complete, the angle of squint is even larger than before the drops were used. These patients continue to make an accommodative effort and it is this effort rather than the peripheral mechanism of accommodation which provides the stimulus causing overconvergence.

The use of drugs which stimulate the peripheral accommodative mechanism (pilocarpine, eserine, DFP), thus obviating the need for an accommodative effort, has, therefore, been advocated for diagnostic and therapeutic purposes. These drugs have proved to be of considerable help.

GENERAL PRINCIPLES OF DIAGNOSTIC TESTS

Objective and Subjective Tests

Although the tests used in the examination of the neuromuscular apparatus of the eyes are technically of the simplest, they may give thoroughly misleading results, unless the examiner is well acquainted with the essence of the tests and the proper technique in applying them. This is especially true since a number of these tests belong to the so-called "subjective" variety.

By "objective" tests are meant such tests in which the cooperation of the patient is reduced to a minimum—steady fixation—whereas in the "subjective" tests the result is determined by the patient's response to the test situation. There is nothing intrinsically better about the objective tests used routinely for the examination of the extraocular motility and binocular cooperation. In fact, some of the subjective tests have actually a greater potential accuracy than the corresponding objective tests. Both types of tests are necessary to obtain a full picture of the neuromuscular situation in a patient.

Role of the Test Situation

A major problem in all tests concerned with the behavior of the neuromuscular apparatus of the eyes is given by the stimulus situation with which the patient is presented. The correct selection of the stimulus situation is essential in obtaining the proper response and it may have to be varied in accordance with the nature or the particular aspect of the function which is being investigated. Thus, for instance, in determining the angle of squint for near a small fixation object, such as a small picture containing fine detail, will bring out the accommodative element much better than the bulb of a flashlight. The patient must exert his accommodation to see the details of the picture. He can see the flashlight without making a particular effort. It can easily be shown that the deviation measured may vary widely in accommodative cases in accordance with the type of fixation object chosen.

The role of the fusible material available to the patient in his binocular field of vision is also of paramount importance. Its presence may be objectionable or desirable, depending on what is being tested. In order to obtain the maximum deviation in determining the angle of squint subjectively by means of a Maddox rod or red glass, it is necessary to exclude insofar as possible all fusional stimuli. On the other hand, the presence

of a large amount of fusible material is desirable to bring out the patient's full potential when testing his fusional amplitudes with a rotary prism or on a major amblyoscope. Similarly, one may be misled into concluding that a patient with exophoria has a very defective binocular cooperation, because he is unable to superimpose dissimilar targets in a stereoscope. However, the same patient may actually show that he possesses good stereopsis when tested with stereoscopic targets. Such patients need more potent stimuli to keep their eyes properly aligned and to exhibit normal sensory function than do people without exophoria.

DETERMINATION OF THE ANGLE OF SQUINT

Estimation of the Deviation

When it is not possible to measure the angle of squint because the patient cannot fixate or is too young to be tested by more quantitative methods, the deviation must be estimated by judging how far the reflection of a small light source is displaced from the center of the cornea toward the limbus. One millimeter of displacement from the center of the cornea corresponds roughly to 7 arc degrees.

This test can be made to be more quantitative in older children and adults by having the patients fixate on a light source and placing prisms of such power and direction in front of the fixating eye that the reflection of the fixation light is now centered on the cornea of the deviated eye. Errors due to parallax must be avoided by the examiner who should align himself as nearly as possible with the deviated eye of the patient.

In all tests in which the deviation is estimated by light reflection from the cornea the angle kappa is, of course, included in the estimate.

Prism and Cover Test

The main problem in the quantitative determination of the angle of squint is to achieve *effective dissociation* of the eyes. If dissociation is not complete the full amount of the deviation may not be elicited.

The prism and cover test makes use of an optomotor reflex which is initiated by the intent of the patient to fixate when the image of an object falls on a peripheral retinal area. This is the case when an eye deviates under cover and when the cover is transferred to the fixating eye. The movement of redress of the deviated eye is quantitative, i.e. proportional to the deviation. If the image of the fixation point is shifted nearer to the fovea by placing prisms in front of the eyes, the movement of redress is correspondingly smaller. It ceases altogether when the image is brought to fall on the fovea, i.e. when the angle of squint is fully offset by prisms.

In order to insure proper dissociation of the eyes, each eye in turn should be well covered and the test must not be performed too hurriedly, but the transfer of the cover must be effected quickly enough to avoid binocular stimulation while the cover is being transferred. In determining the endpoint it is of help not to stop when prisms of a certain strength appear to have neutralized the movement of redress, but to continue on until a definite movement in the opposite direction is noted and then to reduce the prism strength again until no movement occurs.

In some instances, especially in patients with exophoria, it is occasionally necessary to occlude one eye for 10 to 15 minutes to obtain dissociation of the eyes.

The prism and cover test is also widely used in determining the angle of squint in the secondary and tertiary diagnostic positions of the eyes to uncover and diagnose the possible presence of an incomitance, especially when vertical deviations are combined with horizontal deviations.

Objective Determination of the Deviation on a Major Amblyoscope

The objective determination of the angle of squint on a major amblyoscope is based on the same principles as is the prism and cover test.

In using these instruments it must, however, be taken into account that with their use the esodeviations measured are often larger, and the exodeviations smaller, than with the prism and cover test. This is due to so-called *instrument convergence.* A comparison of major amblyoscope findings with prism and cover test findings is, therefore, advisable. Exclusive reliance on major amblyoscope measurements is not recommended.

Subjective Determination of the Deviation

The subjective tests used in the determination of the angle of squint are of two types. The first type, represented by the red glass and Maddox rod tests may be designated as the *diplopia type.* In the tests belonging to this group a single stimulus (fixation light) is imaged on the fovea of the fixating eye and on some peripheral area of the retina of the deviated eye. It is the task of the patient to report where he localizes the image perceived by the deviated eye.

The second type of tests may be termed the *haploscopic type* and is represented, for example, by the Lancaster red-green test or the test for the subjective determination of the angle of squint on a major amblyoscope. In this group of tests

there are always two stimuli presented to the patient, one to each eye. It is the task of the patient to adjust the position of the stimuli in such a way that they appear to him to be superimposed.

Assuming that the patient has normal retinal correspondence either type of test can be utilized to measure his deviation. However, the conditions of stimulation may create certain difficulties which must be considered.

In the haploscopic type of tests the patient will see the stimuli superimposed where they are imaged on the foveas of the two eyes. Now patients with heterotropia have a peculiar aversion to bifoveal stimulation. They will often try to avoid it by suppression, changes in the angle of squint or changes in retinal correspondence whenever the stimuli come to fall on the foveas of the two eyes. It may become then quite difficult to determine the angle of squint subjectively.

The same difficulty may also be encountered when the angle of squint is offset by means of a rotary prism in the diplopia or Maddox rod tests. I prefer, therefore, to use a tangent scale or tangent screen and to ask the patient to report how he localizes the double images. Suppression is also often a disturbing factor in the diplopia type of tests, but it can almost invariably be overcome by patience and some relatively simple manipulations (placing the filter or Maddox rod first in front of the dominant eye, making the patient fixate with the habitually deviated eye, placing a vertical prism of 5-10 prism diopters in front of one eye for a short time, etc.).

The haploscopic type of tests in any one of its many variations is particularly useful in cases of incomitance, especially when paresis of the vertical muscles are involved.

It must be realized that in all subjective tests a thorough dissociation of the eyes is just as important as in the objective tests. The filters used, or the arms of the major amblyoscope with their two targets, fulfill a twofold function: that of *dissociating* the eyes and of *differentiating* the visual fields of the two eyes. Whatever arrangements are used, they must be so devised as to satisfy both requirements.

FURTHER PROBLEMS IN DIAGNOSIS

Amblyopia and the Determination of Visual Acuity

Because of the great importance of *amblyopia ex anopsia* and the need for its early treatment it is imperative that an estimation of the visual acuity of a squinting patient be made as soon as possible. In infants the visual acuity cannot be determined by routine methods, but it is a safe rule to assume that if one eye is constantly deviated, or only rarely assumes fixation, this eye is or will become amblyopic. Treatment should be immediately instituted. In small children it is possible to estimate the vision by making him place marbles in holes, and similar devices, and in somewhat older children picture charts or illiterate "E" charts may be used.

It is of interest to point out here a peculiar behavior of amblyopic eyes. It is invariably true that the acuity of an amblyopic eye will be found to be higher if it is determined by isolated symbols rather than by symbols arranged in rows, as in a regular acuity chart. This is not the place to enter into a discussion of the reasons for such a response of amblyopic eyes. I wish, however, to emphasize that all patients with *amblyopia ex anopsia* should be tested with isolated letters, preferably illiterate "E"s which can be turned in various directions to increase the reliability of the test. Such isolated symbols are easily devised by cutting them out of a visual acuity chart and pasting them on squares or circles of non-glossy white cardboard of six or seven inches in sidelength or diameter.

Problems of Sensory Cooperation

Information about the sensory cooperation of a patient is of importance not only when the question of a possible functional cure arises. In many everyday situations it may become an eminently practical problem to obtain this information, for example when one is faced with the decision whether or not to operate on an adult with comitant strabismus and normal vision in each eye. In such a case our concern is not only with the cosmetic result, but also with a possible postoperative diplopia.

Actually, the sensory binocular cooperation can be tested with relatively simple means and does not necessarily require the services of an orthoptist, desirable as these may be.

Essentially there are three conditions which present problems and about which the ophthalmologist may seek information. These are the presence and depth of *suppression,* the *status of the retinal correspondence* and the *extent of the sensory cooperation.*

Disregarding the more complex methods of examination it can be stated that suppression can be evaluated by the ease—or the difficulty—with which diplopia can be produced in a patient by the use of prisms. For example, if an adult patient with heterotropia responds immediately with diplopia when the angle of squint is nearly offset by prisms and keeps on seeing double after wearing these prisms for some 15 to 20 minutes, caution is indicated in recommending a surgical procedure. If the production of diplopia meets with difficul-

ties, the surgeon can approach the operation with some confidence that presistent postoperative diplopia may not ensue. The Lancaster red-green test is also convenient in establishing quickly whether or not there is deep suppression in the binocular field of vision.

As for retinal correspondence there are two very simple tests which every ophthalmologist can readily apply. One is the *red glass test* which belongs to the group of diplopia tests, the other the *after-image test* which is a form of haploscopic test. In the former a dark red glass is placed in front of one eye; thus the two images of a fixation light—one falling on the fovea of the fixating eye, the other on a peripheral retinal area in the deviated eye—are differentiated. If the patient reports that he sees two images separated by the distance required by his objectively determined angle of squint, he has normal correspondence; if not, his retinal correspondence is anomalous.

In the after-image test the visual directions of the two foveas are directly determined by establishing whether the centers of a vertical and horizontal after image, produced in the right and left eye, respectively, by fixating gaps in luminous lines appear to the patient to coincide or whether they are separated. In the first case the retinal correspondence is normal, in the second anomalous.

The therapeutic problems in which the status of the retinal correspondence is of significance are, for example, whether or not a functional cure may be expected, whether bifocals should be prescribed for a child and whether postoperative paradoxic diplopia may be anticipated in an adult.

The third condition—the extent of the sensory cooperation—may be tested by means of the *Worth Four Dot Test* in its modifications for distance and near fixation, and with a *stereoscope*. The Worth Four Dot Test reveals whether a patient suppresses, has diplopia or has fusion. The stereoscope allows one to ascertain whether he responds normally with superimposition, fusion and stereopsis to the various test cards. Prisms may be used to offset or reduce the angle of squint where necessary. When testing someone with a stereoscope it should not be forgotten, as has been pointed out before, that in certain patients cards containing strong fusional stimuli should be employed to reveal the potentialities of their sensory binocular cooperation.

Problems of Motor Cooperation

The problems of the motor cooperation relate to the ability of the patient to coordinate the activity of his extraocular muscles. Gross defects in the *versions* can be detected by testing the rotations. In the presence of an incomitance it can be established by one or more of the objective and subjective tests which muscle or muscles are involved.

In determining the ability of the eyes to perform *vergence movements* it is necessary to remember that these movements are produced by a shift in tonus in the extraocular muscles which occurs reflexly upon disparate stimulation of the two retinas. It takes a measurable amount of time for this shift to occur and a new distribution of tonus is not immediately achieved when the stimulus is removed. In other words, the effect of the stimulus persists for some time. It is evident from this that the power of a rotary prism should be increased slowly in measuring fusional amplitudes. One must, as it were, give the eyes time to "catch up" with the disparate stimulation, otherwise the fusional amplitudes of the patient will be underestimated. It also follows that it is unwise to determine fusional amplitudes of opposite sign (for instance convergence and divergence) immediately following one another. It is better to interpose the measurement of one of the vertical amplitudes.

Lastly, I wish to point to one feature of the determination of the fusional amplitudes which is frequently overlooked. The measurement of these amplitudes with a rotary prism has no meaning unless the heterophoric position of the patient's eyes is known. *The zero mark on the rotary prism has no physiologic significance.* Thus if a patient shows for distance an amplitude of 10 prism diopters base out and 20 prism diopters base in, his actual power of convergence is quite satisfactory, if he has an exophoria of, say, 12 prism diopters. The effective convergence in this case would be 10 prism diopters plus 12 prism diopters (the amount of exophoria which he has to overcome to keep his eyes straight) equals 22 prism diopters, whereas his divergence power is in effect 8 prism diopters (20 prisms diopters minus 12 prism diopters). If the amplitudes of fusion are measured on a major amblyoscope with the arms set at the subjective angle of the patient, as is customary, the amounts of 22 prism diopters of convergence and 8 prism diopters of divergence would automatically be obtained in this case.

GENERAL PROBLEMS IN THERAPY

Age of Readiness for Treatment

To the question: How soon should the treatment of a child with strabismus be started?—there is only one answer: As soon as the strabismus is discovered. Such statements as: Wait until the ophthalmologist can examine the child; Wait and the child will outgrow its squint, have been recognized to be fallacies. Of late years there is general

agreement that no child is too young to have some form of treatment, although not all forms of treatment are suitable for children of every age.

General Principles of Treatment

It was stated at the beginning of this paper that an etiologic diagnosis must be made, since this diagnosis determines our choice of therapeutic procedure. The reason for this is the basic principle governing the treatment of comitant strabismus that, insofar as this is possible, innervational conditions should be treated by nonsurgical means, whereas non-innervational conditions require surgical treatment. I am firmly convinced that patients with purely accommodative strabismus or pure convergence insufficiency should not be operated upon. I am just as firmly convinced that it is useless to attempt to cure a "basic" heterotropia, as defined above, with glasses or exercises. Such patients are in need of surgery. A combination of innervational and non-innervational elements is present in the majority of patients and a combination of nonsurgical and surgical means of treatment is, therefore, indicated in most cases.

NONSURGICAL TREATMENT PROBLEMS

Problems of Optical Correction

Correction of the refractive error is the firm basis of the nonsurgical treatment of strabismus. The patient must be given appropriate glasses and must wear them for a certain length of time so that their effect on the deviation can be evaluated.

Simple as it may seem, the optical correction poses many problems, some of which will be briefly discussed.

What are "appropriate" glasses? In general we shall wish to give to the patient with esotropia the maximum plus (or minimum minus) correction; to the patient with exotropia the maximum minus (or minimum plus) correction. Does this mean that we should always prescribe for the esotropic patients the full cycloplegic findings?

The visual acuity afforded by the glasses must be adequate to serve the patient's needs. In a preschool child the full atropine correction is as a rule well tolerated since the distance vision is of minor importance. In older children the vision with the glasses must not be worse than without them, in order to induce the child to wear the glasses at all times, and maximum obtainable visual acuity is desirable for work in school. In older children the cycloplegic findings will, therefore, have to be reduced in ordering glasses.

A problem which is sometimes overlooked is that of the *smallest* hypermetropic correction which it is worth prescribing for children with esotropia. I have found frequently that a correction as low as + 1.00 D sph O. U. has a decidedly beneficial effect on the alignment of the eyes. I should urge that even such corrections always be tried, especially in the somewhat older children.

The wearing of glasses may produce one of the following results: (1) it may reduce the angle of squint to zero for distance and near fixation and the child may even gain normal binocular vision; (2) the angle of squint may be reduced to zero or almost to zero for distance fixation, but there may remain a significant deviation for near; (3) the angle of squint may be reduced, but not eliminated for both distance and near fixation; (4) neither the deviation in distance fixation nor the deviation in near fixation are affected by wearing the spectacle correction.

In case (1) we are in the presence of a purely accommodative esotropia; in case (4) the accommodative factor is absent or only of minimal importance; in cases (2) and (3) the wearing of the glasses has given a partial result. Particularly in the patients in group (2) one should investigate the effect of additional plus lenses on the deviation in near fixation. If such additional lenses reduce the angle of squint to a minimum and if the patient has normal retinal correspondence, bifocal glasses are in order.

In prescribing *bifocal lenses,* I have found that it is wise to follow certain rules. In general, children tolerate and use bifocal glasses very well, but care must be taken that the bifocal segment is large and set high enough. I prefer a large segment (28 mm. wide or more) with a straight top which is set so high that the top of the bifocal segment bisects the pupil when the child looks straight ahead. The strength of the bifocal segment must be determined by measurement in every case (prism and cover test) and the minimum additional plus power is chosen which will keep the eyes straight, or most nearly straight.

While we always tend to prescribe the maximum plus correction for esotropic patients and even order bifocals, the maximum plus power is not always the appropriate glass for a child. When we wish to enable patients with accommodative strabismus to do without glasses we will often attempt to reduce the plus correction, in the course of time, and seek the weakest lenses which will ensure proper alignment of the eyes. Such a procedure, in combination with orthoptic exercises to dissociate accommodation and convergence and to develop fusional amplitudes, is usually the treatment of choice in accommodative esotropia. On the other hand, minus lenses overcorrecting the myopia, or even in the absence of a myopia, are

sometimes given to stimulate accommodation in intermittent exotropia and similar situations.

The optical correction is not always aimed at the normalization of the relationship of accommodation and convergence alone. Occasionally we shall want to influence the angle of squint directly by means of *prisms*. A general discussion of the use of prismatic corrections is outside the scope of this presentation. I wish to point out here only that vertical prisms are often very helpful in assisting in the restoration of secure binocular vision, especially where there is a small vertical deviation present after surgery on the horizontal muscles.

Problems of Occlusion Therapy

The great value of *constant and complete occlusion* of the fixating eye in the treatment of *amblyopia ex anopsia* is so well established that it is unnecessary to dwell upon it. However, it must be pointed out that those who have made use of occlusion therapy have found that in addition to being an excellent means of restoring vision to amblyopic eyes it is also helpful in improving the excursions of an eye, as in the frequent weakness of abduction in esotropia, and that, in the form of alternate occlusion, it is a potent adjunct to the therapy of anomalous correspondence.

For all its usefulness in combating amblyopia occlusion as such is a *passive form of treatment*. It can only be really effective if the patient makes an effort to use the amblyopic eye. It is wise to impress this on the parents and to plan with them a regular schedule of tasks to be performed by the patients with the amblyopic eyes.

While occlusion is in itself a very simple procedure, it nevertheless raises a great many problems. When should one occlude? How long should one occlude? At what age does occlusion become ineffective? What are the side effects of occlusion and are there any contraindications?

Briefly stated, occlusion of the fixating eye is indicated whenever there is direct or presumptive evidence for an amblyopia ex anopsia. As has been pointed out, presumptive evidence exists when a baby whose visual acuity as yet cannot be determined presents a constant, strictly monocular deviation. Occlusion should be continued until the vision in the two eyes is equal, or until there is no further improvement in the vision of the amblyopic eye over a period of two or three months. If the vision of the two eyes has become equal or nearly equal, one may then proceed with alternate occlusion, the goal being to achieve free alternation and normal retinal correspondence.

It is clear that occlusion is the more likely to succeed, the younger the child is when the treatment is begun. But even in older children good results can be obtained, given sufficient cooperation on the part of the patient. Actually, the potentialities of an amblyopic eye for an improvement of its visual acuity are never entirely lost. With the strongest motivation of them all for the use of an amblyopic eye—the loss of the fixating eye—a remarkably high degree of visual acuity does occasionally return even to amblyopic eyes of adults and indeed of persons of advanced age.

The side effects of occlusion may relate to the eyes themselves or they may be of a more general nature. Reduction in vision of the occluded eye, production of a manifest deviation or of a so-called "occlusion hyperphoria" are relatively easily dealt with by the experienced ophthalmologist. General reactions (stammering, etc.) are rare but they may be severe enough to make it necessary to stop this form of treatment. Occlusion is contraindicated in the presence of a large anisometropia (4 or 5 D or more).

Problems of Orthoptic Treatment

Orthoptic treatment is a vast subject which poses many problems. It can not be discussed here in its broad aspects. Only a few points relating to comitant strabismus will be raised.

In the treatment of patients with comitant strabismus there are two areas in which orthoptic exercises are particularly useful. One is made up of patients in whom sensory and innervational factors are the predominant cause of the strabismus and in whom orthoptic training of itself constitutes sufficient treatment. The other field of application is the field of sensory abnormalities existing in comitant strabismus. The sensory defects—such as amblyopia, suppression and anomalous correspondence—must be removed if a functional cure is to be achieved. It is attempted by orthoptic exercises to give the patient good fixation and good vision in each eye and to rid him of abnormal suppression and anomalous correspondence. If one has been successful in this and if, where necessary, the alignment of the eyes has been corrected by surgery, the attempt may be made to improve the binocular cooperation further by giving the patient fusional amplitudes. If one succeeds in establishing good amplitudes, the patient may also attain stereopsis.

Secure binocular vision is unquestionably a highly desirable goal. Orthoptic exercises are a valuable means of helping the patient to achieve this goal. But they should be used with discretion. Not every case which may be amenable to orthoptic treatment must also necessarily be so treated.

Obviously, all cases should be given orthoptic treatment in which it may reasonably be expected

that exercises may influence beneficially the manifest deviation. The same holds true especially for all cases of latent deviations in which exercises may rid the patient of symptoms. If it is neither a matter of reducing a deviation or giving comfort, but a matter of establishing binocular cooperation, judgement should be exerted in the selection of cases. It may be the part of wisdom—for social as well as medical reasons—to leave some patients alone and to rest content with a cosmetic surgical result.

Nor should orthoptic treatment be instituted in the belief that abnormal sensory conditions affect the surgical result adversely. Preoperative orthoptic treatment is doubtless desirable, but I have never been able to prove to my own satisfaction, except in cases of eccentric fixation, that the failure of an operation was due to the presence of sensory anomalies, say to an abnormal correspondence. To be sure, the surgical result is best if the patient has or regains binocular vision. This transforms the heterotropic patient into an heterophoric individual and such an individual, by definition, keeps his eyes straight. But this is not to say that the sensory status of the patient as such endangers the result of an operation.

It seems to me that ideally every patient with comitant strabismus who comes to the attention of an ophthalmologist should have an orthoptic evaluation. This orthoptic evaluation will tell the ophthalmologist whether or not the conditions are favorable for orthoptic training and whether or not orthoptic training would seem to be desirable. If training is indicated, then the patient should have pre- and postoperative treatment, if operation is needed. The preoperation treatment should be carried out to the point at which in the opinion of the orthoptist and the ophthalmologist the treatment has yielded the maximum benefit which can be expected. The postoperative treatment should begin as soon as possible after surgery, preferably within a matter of days.

SURGICAL TREATMENT PROBLEMS

General Indications for Surgery: Age of Patient

In considering surgical treatment the first question to be answered is this: Why do we operate on this patient with comitant strabismus? The answer to this question may be: for cosmetic reasons, or to achieve a functional result, or both.

It is necessary to ask this question whenever surgical intervention is contemplated, since the surgical procedure to be chosen depends to some extent on the purpose for which it is performed. For example, if we operate solely for cosmetic reasons, the age of the patient is in itself no factor in the success, although type and extent of operation vary with the patient's age. If a functional result is aimed at, the age of the patient is most important. It stands to reason that the earlier an operation is performed the better are the chances for a functional cure by allowing the patient to grow up with properly aligned eyes.

But how early is early? Should we operate on a 6 month old infant? Or is the lower age limit 18 months or 2½ years? Some of the most experienced surgeons in this field operate on children as young as 9 to 12 months old, but I am inclined to be more conservative. Unless the angle of squint is very large and constant and the refractive error insignificant, I prefer to wait until such a time when I feel that I have sufficient information to make with confidence a decision about the surgery to be performed.

As I have pointed out, the surgical procedure must be directed against the non-innervational factors. To analyze a case of strabismus in an infant is not always easy. The angle of squint tends to be variable. We know of the prevalence of tonic convergence in young children and we know that there is, in general, over the years a trend toward a reduction in the angle of squint. But there are certain facts which help us in the analysis of these cases.

If one eye is constantly deviated, this is presumptive evidence of an existing or potential amblyopia ex anopsia. Occlusion—or if this is not feasible—atropinization of the fixing eye, must be instituted. The effect of the wearing of a refractive correction should be investigated even at this early age. The behavior of the excursions of the eyes should be known. When effective nonsurgical treatment is instituted and the patient is carefully supervised there is no time lost and no danger in postponing the operation until the child is 2 or 2½ years old, by which time much other valuable information about the case can be gathered.

Choice of Operation

When the decision has been reached that surgery is necessary, the problem arises which muscle or muscles to tackle.

Since there are fundamentally only two procedures which can be performed on the extraocular muscles, one must either weaken the action of an agonist, or strengthen the action of the antagonist, or both. To determine which course of action is the wisest, one should always keep in mind that it is best, whenever possible, to work on the muscles whose action is in some way at fault.

How does one go about ascertaining which ones these muscles are? A careful study of the ocular

rotations has proven most useful to me in accomplishing this task. In most cases of esotropia one will find more or less of an excess of adduction and occasionally a more or less pronounced defect of abduction. In patients with exotropia there may be a weakness of adduction or an excess of abduction, or both. Correspondingly, there are deficient and excessive actions of vertical muscles when a vertical deviation is combined with a horizontal deviation.

In attempting to straighten a pair of eyes by surgery, *the goal should be to normalize the excursions of the eyes.* When this is achieved, the angle of squint is usually automatically reduced to a minimum.

In accordance with these principles I always weaken the action of an overacting muscle, or strengthen the action of its antagonist when there is a weakness, or combine the two procedures when both the agonist and the antagonist appear to be at fault.

The attempt to normalize the rotations implies that we wish the postoperative result to be such that the ocular movements are even, smooth and comitant. This desire to achieve comitance has lately led to renewed emphasis on symmetrical operations on the two eyes, especially on simultaneous recessions of equal amount of the two medial rectus muscles for patients with esotropia. It seems to me that the routine use of one type of operation—either symmetrical or asymmetrical—is not desirable. I prefer to stress symmetrizing rather than symmetrical operations.

If the study of the rotations reveals an asymmetry, I shall attempt to remove this asymmetry by making a more extensive operation on one muscle than on the other, say a 3 mm. recession of the medial rectus of one eye and a 5 mm. recession of the medial rectus of the other eye. If the rotations of one eye are much more abnormal than those of the other eye—as is so often the case in monocular squint—I may do a recession-resection operation. Here again, I shall be guided by the behavior of the rotations in determining how much to do. I shall always rely on one operation as the main operation, aimed at the more abnormal rotation, using the other more or less as an adjunct. The important thing to be remembered is that one should always make a fresh decision in each individual case; routine use of one type of surgery to the exclusion of all others is bound to lead to disappointment.

Factors Affecting the Surgical Result

The effect of operations on the extraocular muscles is notoriously unpredictable in terms of degrees of correction per millimeter of recession or resection of a muscle. This is a source of much distress to those who are first approaching the subject.

With increasing experience one finds, however, that certain factors afford helpful hints as to the probable effectiveness of a certain procedure in a given case.

Generally speaking, the effect of the same operation is relatively greater if the angle of squint is large and if the rotations are more abnormal, than when the same operation is performed on a patient whose angle of squint is small and the rotations are less abnormal. I interpret this to mean that the more stable the angle of squint and the less prominent the innervational factors, the greater is the effectiveness of an operation.

It must also be kept in mind that the effectiveness of an operation is much less predictable when an innervational element, especially an accommodative element, is prevalent. I have not found, however, as was mentioned before, that such sensory factors as anomalous retinal correspondence influence the surgical result adversely. But the presence of an extreme, intractable amblyopia is, indeed, often a major obstacle to a satisfactory surgical result. If one does not do enough, for fear of overdoing, the eye will frequently return to its peroperative position. If one does a more radical operation, because of the well known tendency of the eye to slip back, one may obtain an overeffect.

Lastly, one of the most important factors affecting the surgical result is the technique employed. The manner of freeing the muscle, the manner of placing the sutures, the manner in which a muscle is severed from the sclera, the manner in which the wound is closed, the amount of scar tissue produced, all have a more important effect on the final outcome of the operation than the actual amount or recession of the insertion. In the last analysis each man has to work out his own technique in this respect. And it is because of the differences in operative technique that only operations done by one man in the same fashion are really comparable and that it is so very difficult to advise someone else how much of an operation he should do in a certain patient.

Year Book of Medicine: 1956-57, by Board of Editors. (*$6.75. Year Book Publishers Inc., Chicago 11, Ill.)* Hundreds of papers have been selected for abstracting by competent workers and comments made by the distinguished editors. The current volume if anything is better than its predecessors and constitutes a must for physicians who wish to keep abreast of the times.

Penetrating Foreign Body

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness, which can in many instances be averted by proper, timely care.

Case Report

Explosion of a cartridge occurred when this 12 year old boy struck it with a hammer. Minimal blurring of vision and slight pain in the right eye was noted immediately. The boy did not disclose the nature of this incident until a week later and the mother, not suspecting a major injury, did not call a physician for three days. After three days the eye had become extremely painful and red, was filled with greyish purulent material, perceived only light, and was considerably proptosed.

The diagnosis of panophthalmitis and orbital cellulitis was easily made. X-ray showed a 1 by 2 by 4 mm. metal fragment lodged in the orbit. This had apparently traversed the globe, leaving visible only a minute laceration in the inferior cornea. The patient was given 1,000,000 units of penicillin, 2 Gm. of streptomycin, and 6 Gm. of Chloromycetin® daily. Surgical removal of the infected fibrin clot from the anterior chamber was done, and the wound sutured.

Within 24 hours no organisms could be cultured from the eye, and several days thereafter the inflammation had greatly subsided. There remained a densely opaque and organized vitreous, and barely light perception was present one week following the injury.

Discussion

The danger of leaving any type of high explosive accessible to children is too obvious to require further emphasis. A surprising feature of ocular injury by tiny, high velocity fragments is the very slight pain and minimal visual disturbance noted at first. The wound of entry is tiny and inconspicuous and is easily overlooked in the transparent cornea. A small, innocent-appearing subconjunctival hemorrhage may conceal a scleral entry. Fluorescein staining may be helpful in localizing a wound during the first half day, but usually the wound is healed and does not stain within a day or two. Small holes in the iris are readily seen, especially in the ophthalmoscopic red reflex, and usually signify penetrating ocular injury. Presence of a traumatic cataract is another indicator of penetrating injury. One should certainly obtain a roentgenogram whenever the possibility of a penetrating wound exists.

Intraocular bacterial infections may develop very rapidly. Once well established, such infections almost invariably destroy sight. Best results are achieved by prompt and intensive prophylactic antibiotic therapy, instituted within a few hours of injury. Upon making the diagnosis of intraocular penetration, the physician is well advised to give a generous dosage (note dosage in above case) of antibiotic immediately, before sending the patient to his ophthalmologist.

Iron and copper particles will cause chronic degeneration if lodged within the eye, and should be removed if at all possible. It is most difficult to remove nonmagnetic particles from the posterior eye. Extraocular foreign bodies are well tolerated, and the trauma of removal is ordinarily not justified.

Use of protective goggles is most valuable in preventing industrial eye injuries of this type. Even an ordinary pair of glasses will give almost complete protection against very tiny particles. Frequent offenders are stone and metal chips from hammering and chiseling in the course of home repairs. Goggles should certainly be worn when working about power grinding and cutting tools.

The Author

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Erratum

In the December 1957 issue of *The Journal,* (pages 1421-1423), a mistake was made in the article entitled "Upper Respiratory Infections, Antimicrobial Agents and Acute Rheumatic Fever," by David H. Greegor, M. D. The administration of 300,000 to 600,000 units of procaine penicillin every three days for three injections has not been recommended by the American Heart Association as a method for therapy of streptococcal infections in the prevention of rheumatic fever.

The dose is correct, but the preparation is procaine penicillin *with aluminum monostearate in oil.*

Vertigo and Dizziness

DWIGHT M. PALMER, M. D.

The Author

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Introduction

VERTIGO is the medical term used to describe the condition in which the patient experiences an unusual and abnormal sensation of turning or rotating. The term, *vertigo,* is derived from the Latin verb, *vertere,* meaning to turn; and the diagnosis implies that the subject has a subjective impression of either turning of his head or body in space or that perceived space is turning or rotating about the patient himself. Vertigo is an aspect of disordered equilibrium.

Dizziness comes from the Anglo-Saxon word, *dysig,* meaning foolish and the real meaning of the term is that of foolishness or mental confusion or unsteadiness of mind. However, the word dizziness is commonly used, as is a parallel term, *giddiness* (from the Anglo-Saxon, *gydig,* signifying insane) to describe conditions of unsteadiness, sensations of falling and lightheadedness as well as true vertigo.

Moreover, to add to the confusion, both words, dizziness and giddiness, have been used to describe mental uncertainty rather than confusion of mental content. The term, *lightheaded,* should refer to floating or lack of mooring of the head and hence to fickleness or uncertainty, or perhaps to a lack of stability and solidarity in one's position. But, again, lightheadedness has been used to describe a variety of states ranging from vertigo through dizziness to faintness. The latter term derives from ancient meanings which implied a pretending of weakness. This usage may have been based upon the insight that the faints of some persons are escapes from reality, although not necessarily consciously motivated as such. The modern meaning of fainting is that of impaired consciousness due to lack of blood supply to the brain.

It is important that the terms vertigo and dizziness be defined carefully and that they be differentiated from each other as far as is possible. The two states should also be separated from the condition of faintness or syncope. Some authors have attempted to separate vertigo from dizziness by calling vertigo true dizziness or just dizziness, and by denoting ordinary dizziness as false dizziness. This is more or less a play with words and, in the opinion of the author, may only add to the confusion. Other writers have tried to define vertigo as a feeling of turning or rotating as stated above, and to equate the conception of dizziness with syncope or fainting. The latter usage does not appear to be accurate since some patients with dizziness have a normal cerebral blood supply.

It would appear that a better approach is for the physician to carry out protracted and detailed history taking from his patients in order to determine just what the patient means when he uses such common terms as dizzy, giddy, faint, lightheaded, etc. Then, it will probably be found that a rather small percentage of patients will mean vertigo, while others will imply lightheadedness, giddiness or faintness; and still others may allude to fear and insecurity.

Anatomy and Physiology

The positioning of the body in space is accomplished by the use of sensory information brought in from the receptors in the vestibular mechanism, the eyes, the tactile receptors, principally those in the soles, and the muscle-tendon receptors, especially those in the lower limbs, back and neck. This information is received and classified or associated in the cerebellum and in the temporoparietal lobes of the cerebrum. Those parts of the brain feed patterns of impulses into the descending extrapyramidal and pyramidal tracts to give motor equilibration. At the same time the person has a subjective feeling of being secure in space.

If the space perceptions from the different sensory organs are not in harmony with each other, the individual will be uncertain about his position in space and he will sense this as some form of vertigo or dizziness. As long as the individual is not aware of the conflicting sensory impressions he will not be vertiginous or dizzy. For example, a person may be rotated in a revolving chair many times without causing him to have vertigo if the room is absolutely dark.

THE VESTIBULAR MECHANISM. Each membranous labyrinth is a complicated coiled epithelial tube that lies inside a corresponding bony labyrinth within the petrous portion of the temporal bone. The membranous labyrinth consists, on each side

of the head, of three curved tubes which are called semicircular canals and of two sac-like structures, the utriculus and the sacculus. All of these are connected parts of a single hydrodynamic system.

The semicircular canals serve as a mechanism not only to record the movement of the head but also the termination of the movement. The central connections of this apparatus serve to correlate these happenings with other functions. The main adjustment is between movements of the head and those of the eyes. During movement of the head in one direction the eyes are held toward the opposite direction and then, as movement of the head stops, the eye movement is reversed and the eyes are brought into line with the direction of the head. Ordinarily, the movements of the eyes are so quick as not to be noticeable. However, if the rotation of the head is sudden and prolonged an apparent jerking of the eyes, called nystagmus will occur.

In contrast to the semicircular canals, it is believed that the utriculus and sacculus give rise to a continual discharge of sensory impressions, a constant recording of the position of the head over long periods of time. This sustained activity supplements the intermittent activity of the semicircular canals.

The Eyes. In man, the visual mechanism is more important in the control of posture at the conscious level than is the vestibular mechanism. The eyes serve to give the individual an orientation of himself in space in terms of a three dimensional picture of a portion of his surroundings. This perception of the environment, to be effective, should be in sharp focus and of good depth throughout its extent.

The Tactile Receptors. A relatively small aspect of posture control is that brought about by patterns which are activated by tactile impulses, especially those from the soles of the feet. This furnishes a sensory input which tends to activate the body image of the cortex and this in turn serves as a focus for the organization of the conscious appreciation of one's position in space.

The Muscle-Tendon Receptors. Each time a muscle is used there is a sensory input from it which conveys information concerning the status of the muscle. These are the so-called feedback circuits which are essential to the regulation of the motor output to the muscles. With respect to posture, the feedbacks from the neck, lower limbs and back are primary components of the machinery for the maintenance of the upright position.

The Brain Stem. The brain stem consists of the medulla, pons and midbrain to which is attached the cerebellum. This position of the nervous system contains many pathways that are associated with equilibrium. The most important ones are those which coordinate the movement of the two eyes in a conjugate fashion in all axes, and those that coordinate eye movements with neck movements and with sensory information from the vestibular mechanism, the skin, the muscles and tendons.

The Cerebral Cortex. Among other functions, the cerebral cortex serves to organize the muscle functions in terms of the consciously perceived needs. There is built up in the parietal lobe an organization of information about the somatic part of the body which is called the body image or body scheme. This is an ever-changing representation which is constantly being activated by incoming information from the receptors—skin, muscles, and tendons, vestibular mechanism and eyes.

Psychological Aspect. There is also a symbolic aspect to equilibrium. The normal person with good equilibrium has a feeling of sureness and certainty about his stability. Such an individual is not concerned with a need to hold on or with a fear of falling. He also has the feeling that his environment is definitely in place and that he has his muscles under control as he relates himself to his surroundings.

Symptoms and Diagnosis

The machinery for the control of posture or equilibrium may be damaged in the inner ear, in the vestibular nerve, in various receptors (the eye, and muscle-tendon receptors), in the brain stem, or in the cerebral cortex. There are also psychopathological considerations.

The Vestibular Mechanism of the Inner Ear.

Labyrinthitis—This may occur in an acute or chronic form. Acute labyrinthitis may be due to infection, injury or vascular disease and may take place at any age. The symptoms usually occur in rather short bouts or episodes, lasting from a few minutes to an hour or two at the most. With each attack there is a sudden onset of severe vertigo, nystagmus, dysequilibrium and usually of nausea and vomiting. The illness may last for several days or even a few weeks with a gradual decrease in severity of the individual attacks.

Labyrinthine vertigo is accompanied by spontaneous nystagmus which appears in both eyes and usually in a horizontal plane, although there may be a mixture of horizontal and rotary components. The patient maintains his consciousness but may be prostrated with vertigo and weakened by a fall in blood pressure. At the time of the

paroxysm there is almost always some tinnitus. If the patient is able to analyze his perceptions, he will say that external objects appear to move in the direction of the fast component of his nystagmus. Between attacks some deafness may be noted, and this may be of diagnostic value when it is unilateral.

Chronic labyrinthitis is not as common as one might expect; the symptoms are mild and intermittent. One interesting variety of this condition is positional vertigo in which the disturbance appears in only one position of the head. It has been postulated that some of these patients may suffer vertebral artery compression on rotation of the neck. However, Dix and Hallpike have reported cases that appeared to be of this positional type of vertigo in which they found definite pathology in the utriculus and sacculus.

Ménière's Syndrome. This is a poorly understood condition that is thought by some to represent a recurrent labyrinthitis, although most workers agree that the exact pathology is not known. It is a fairly common condition, is seen more often in men, and is a disease of middle life. It is described as recurrent paroxysmal labyrinthine vertigo although the cochlear mechanism is also involved in the majority of cases. It is characterized by recurring attacks of severe vertigo accompanied by tinnitus and loss of hearing. Each attack is paroxysmal and may be so sudden as to strike down the person. The patient is usually quite ill with the vertigo and is nauseated and sweaty. He may have nystagmus during the attack. The syndrome tends to continue irregularly but remissions are not unknown. As time goes on there is usually progressive loss of hearing. Each individual attack is usually much shorter than that seen in acute labyrinthitis.

Motion Sickness. This condition is apparently related to overuse and irritability of the vestibular mechanism. There is a great variability in susceptibility to motion sickness and the severity of the vertigo varies from patient to patient.

The Vestibular Nerve. The most common cause of irritation of the vestibular nerve is an acoustic neuroma in the cerebellopontine angle. Along with the vertigo and nystagmus from vestibular involvement there is likely to be tinnitus and impaired hearing from cochlear involvement, and signs of pressure on the ipselateral sixth (abducens) and seventh (facial) nerves.

There is also a vaguely understood condition of vestibular neuronitis. Dix and Hallpike have reported cases of this type in which there was focal infection in the nose and throat and a slight increase in the sedimentation rate.

The Eyes. Visual disorders may cause a variety of complaints ranging from a feeling of insecurity to uncertainty as to one's position in space and staggering. Errors in refraction may cause the person to feel like he is looking through an uneven section of window glass. There may also be alterations in space perception and in the size and appearance of objects. Some of this may be subjective and the patient may feel that either he is far away from the ground or that it is coming up to meet him. There is likely to be severe but usually temporary vertigo following the onset of double vision. If the deviated eye is being used, the patient may feel that the environment is moving.

The Tactile Receptors. Loss of tactile sensation, especially from the soles of the feet, will cause considerable disability in posture and gait. The feeling is not that of true vertigo but of uncertainty as to where the ground is. The difficulty will be increased if the patient has an additional muscle-tendon receptor loss, or if he closes his eyes.

The Muscle-Tendon Receptors. The characteristic difficulty in this condition is the inability to stand with the eyes closed (positive Romberg test), and the inability to walk in the dark. The condition is one of sensory ataxia.

The neck muscles play a greater part in the production of vertigo than is generally believed (Ryan & Cope). Interference with the tonic neck muscle reflexes may distort the sensory picture of body posture carried inward from these muscles and cause a lack of harmony between neck muscles information and ear and eye information. The normal activity of the neck muscles in the process of equilibrium control may be interfered with by arthritis with fixation of the cervical spine, unusual stretching of the neck muscles, or traumatic spasm of those muscles.

The Brain.

Brain Stem. The vertigo of brain stem disease is more continuous and each episode lasts longer than that of inner ear or vestibular nerve disease. In fact, there are no true paroxysms although something of that nature may be elicited by movements of the head.

There are other signs of brain stem disease. The more common of these are: double vision, numbness of one side of the face, difficulty in speech production, incoordination of the limbs, and any form of nystagmus. The nystagmus is coarse and rather oscillating. It is particularly diagnostic when it occurs in only one eye and in a vertical direction. Deafness is rare in brain stem disease.

Cerebral Cortex. The vertigo of cortical irritation may be severe but it is likely to be transient.

When it occurs as a vestibular aura in convulsive disorders, it is extremely brief. Vertigo may also appear as a rather fleeting stage early in the course of a migraine headache.

Entire Brain. Any condition which brings about a sudden reduction in the quantity or quality of the cerebral blood flow will change the metabolism of the cerebral neurones and affect their function. Cortical neurones are especially responsive in this regard, and, within a few seconds of impaired blood supply, will begin to dysfunction.

The subjective experiences of the patient with this condition range from lightheadedness through faintness to blackouts. Prolonged alterations are likely to cause lightheadedness and mental fogginess which the patient may describe as dizziness.

Circulating toxins, either exogenous or endogenous, may have a similar effect on the cerebral neurones.

Mental or Symbolic. An individual who is afraid that he is losing hold of himself mentally or who is concerned about falling from a given position of mental stability may symbolize or dramatize this by complaining of dizziness. He may thus mean that he cannot hold on, that he is uncertain, or that he is afraid he will pass out, etc. Such persons may sway and lurch even rather violently, but they seldom fall down, and if they do, almost never hurt themselves.

Treatment

A correct diagnosis should lead toward treatment directed to the involved area.

Labyrinthine—If there is doubt as to the accuracy of the diagnosis, the patient may be referred to an Eye, Nose and Throat specialist for testing and an opinion.

The removal of any contributing cause such as infection is indicated. The use of salt-free and sodium reduced diets has many advocates.

Potassium iodide in saturated solution (1 to 5 drops in water three times daily), nicotinic acid (100 mg. tablet four times a day), and Benadryl® (50 mg. capsules, one, two or three a day) have been used.

More specific vestibular depressants include Marezine® (one 50 mg. tablet three times daily), Bonamine,® (one or two 25 mg. tablets, once or twice a day), and Dramamine® (one 50 mg. tablet, three or four times a day).

There is no specific treatment for Ménière's syndrome. Spontaneous improvement may occur. A reduction of salt and sodium in the diet has been advocated. Also, the use of drugs like ammonium chloride and potassium chloride as well as Diamox® (one 250 mg. tablet twice a day) has been advocated. Some patients have either been managed successfully with nicotinic acid or else a remission occurred at the time. Those persons unfortunate enough to have the syndrome in a severe and persistent form have been treated by surgical section of the vestibular nerve on the side of the greater hearing loss, or by cauterization of the appropriate labyrinth.

Ocular—Disturbances of visual origin are treated by correcting refractive errors. Patients should be reassured that a change of lenses often requires a period of adjustment. In case of recent diplopia, the deviated eye may be covered in order to relieve the vertigo.

Tactile Sensory—The treatment is that of the background condition. These patients may suffer from anemia, avitaminosis and disorders of the lower spinal cord and spinal cord roots.

Muscle Sensory—The treatment is that of a causative condition which is likely to be neurosyphilis in the form of tabes dorsalis, pernicious anemia or diabetes mellitus.

Brain—If the symptom is that of vertigo rather than of dizziness, and there is a question either as to the clinical diagnosis or the nature of the underlying pathology, the patient may be referred to a neurologist for a diagnostic study and for suggestions as to the management. The treatment is that of the causative pathology—anticonvulsants, antihypertensives, sedatives, vitamins, surgery, etc.

If the symptom is that of dizziness rather than vertigo, a large variety of causative conditions may be operative. These may be in almost any of the organ systems and assistance by a specialist in Internal Medicine may be helpful. These patients may require therapy with hematinics, vasodilators, antihypertensive drugs, and diets.

Mental or Symbolic—It may be necessary to refer these patients to a psychiatrist for a definite diagnosis and for recommendations as to treatment. Some of these patients are managed adequately on supportive, superficial psychotherapy while others require specialized psychiatric treatment.

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Hemangioma of the Kidney

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HEMANGIOMA of the kidney is a very rare benign tumor. Virchow, the German pathologist, reported the first case found at autopsy. Seventy-eight subsequent cases have been reported in the literature. Marks and Lazarus reviewed the literature from 1867 to 1947, and reported 70 cases. Since 1947 eight cases have been reported.

Hemangioma of the kidney occurs in both sexes and is slightly more frequent in men. About half of the reported cases occurred in the third or fourth decades of life, the youngest at four days of age and the oldest at 67 years of age.

McKey noted a considerably greater incidence of left kidney involvement and theorized that the frequency was possibly due to the left renal vein being more subject to obstruction because of its longer course and the crossing in front of the aorta. The compilation by Lazarus and Marks revealed only slightly greater incidence in left kidney, 54.2 to 45.8 per cent, and McCrea's series reports the lesion as often in the right kidney as in the left.

Two types of hemangioma are encountered, capillary and cavernous. The cavernous type is the most common.

They may be single or multiple, they may be in one or both kidneys. Paletz and Sewell reported a case in which a right nephrectomy was done for intractable bleeding due to hemangioma. Two months after dismissal from the hospital the patient re-entered because of the gross hematuria from the remaining left kidney. X-ray therapy was given to the remaining left kidney with subsidence of bleeding in five weeks. The patient was followed for four years without recurrence of bleeding. Bilateral hemangioma was strongly suspected.

Of all the reported cases in the literature only one showed evidence of hemangioma elsewhere in the body, Paletz and Sewell, 1951.

They may be located in the calyces, medulla and rarely in the cortex of the kidney, but are usually found under the mucous membrane of the pelvis of the kidney.

Judd and Simon stated that this type of tumor rarely attains a diameter of one centimeter. Lazarus and Marks came to the conclusion that the lesion is usually very small, but its size may vary from a pinhead to a mass one-third the size of the kidney.

The most prominent symptom is painless, gross hematuria. In many cases renal colic is associated with hematuria due to formation of blood clots in the pelvis or ureter. In many cases reported, intermittent gross hematuria had been present for many years before the condition became so severe that nephrectomy was done. In most cases diagnosis was difficult before surgery and most surgeons made the diagnosis of tumor or cyst instead of hemangioma before operation.

The case being reported had agenesis of the left kidney. It should be briefly mentioned that the failure in the formation of the ureteral bud which organizes the mesoderm of the metanephrogenic blastema about itself for the formation of the permanent kidney is the probable cause of the agenesis of the organ.

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Case Report

Case No.—Mercy Hospital, Canton, Ohio.

The patient, 52 years old, white, male, married, was brought to the emergency room at 11:40 p. m., March 2, 1957, because of sudden, steady, sharp abdominal pain with nausea and vomiting, since half an hour prior to the examination.

Personal History: He had measles, mumps, chickenpox, whooping cough in childhood, with two previous admissions in this hospital: First admission was on November 20, 1942, because of sharp abdominal pain with nausea and vomiting, which lasted 24 hours with the diagnosis of food poisoning. His blood count was normal, but urinalysis revealed one plus albumin. The patient's second hospital admission was on November 24, 1947, for the operation of right and left inguinal hernias. Blood count was normal, but urinalysis revealed microscopic hematuria.

Family History: Noncontributory.

Physical Examination: Revealed a well developed and nourished, short patient in extreme distress com-

plaining of the previously mentioned pain with cold and clammy extremities and cyanotic lips and nails.

Head, eyes, face, short neck, and chest appeared normal; abdominal respiration was vanished. There was severe abdominal tenderness in the right flank, right lower quadrant, right costo-lumbar angle, without muscular rigidity or any palpable mass. Liver and spleen were not palpable. Bowel sounds were absent. Lungs appeared normal. Heart was with regular rhythm and with sounds of good intensity, without any murmur. No palpable enlarged lymph nodes were present. Knee and ankle jerks were physiologic and no abnormal reflexes were present.

Blood pressure 124/104; Pulse rate: 160 per minute; Catheterization of the bladder produced no urine.

Hemoglobin: 15.8 Gm.; Microhematocrit: 43 per cent; White blood cell count: 15,200; Band cells: 10; Segmented: 76; Lymphocytes: 10; Monocytes: 4; Blood type O and Rh positive.

Electrocardiogram: Nothing abnormal.

K. U. B. film: The right psoas shadows were not too well visualized.

Hospital Course: Patient continued complaining of pain with nausea and vomiting until March 4, 1957, when he was taken to surgery for exploratory laparotomy. Right retroperitoneal hematoma was found, which was not disturbed. Peritoneal cavity and the aorta seemed normal.

In the following days he developed paralytic ileus with profuse bloody fluid draining from the incision, and a huge ecchymosis all over the right part of the abdomen developing to the scrotum and upper part of the right thigh.

On March 9, 1957, because of the evisceration, the patient was taken to surgery for the repair, and after the debridement of the wound the incision was closed. Patient gradually developed oliguria, became unconscious, and expired on March 14, 1957.

Laboratory Data Studies

Date	3-5-57	3-7-57	3-9-57	3-11-57
Hemoglobin	9.5	8.2	9.0	8.6
Microhematocrit	34	26	23	37
White Blood Count	20,750	8,350	16,100	40,350
Band Cells	10	24	35	28
Segmented	76	35	55	65
Lymphocytes	10	5	9	4
Monocytes	4	1	----	3
Eosinophils	----	----	1	----
Date	**3-4-57**	**3-11-57**	**3-12-57**	**3-13-57**
Nonprotein Nitrogen	67.5	61.0	62.8	104.0

Blood sugar 160 mg. per 100 cc.; serum protein 5.46 Gm. per 100 cc.; serum albumin 3.20 Gm. per 100 cc.; serum globulin 2.55 Gm. per 100 cc.; serum chloride 100 mEq/L.; serum sodium 104.3 mEq/L.; serum potassium 4.6 mEq/L.

Urinalysis: Albumin four plus; white blood cells, many; red blood cells, many.

Intravenous phenolsulfonphthalein: Revealed no definite excretion of either kidney in 20 minutes. Right side of the abdomen was hazy and renal shadows were not visualized.

Chest X-ray: Revealed elevation of the right hemidiaphragm with atelectasis of the right base, which did not change during the course of hospitalization.

Electrocardiogram: Revealed no significant changes.

Summary of the Autopsy

A summary of the pathologist's report March 14, 1957, is as follows:

The body is that of a 52 year old, white, male measuring 62 inches in length and weighing an estimated 145 pounds. The patient is slightly jaundiced. Abdomen is distended and there is a right low rectus incision with stay sutures measuring 10 inches, and also there is marked ecchymosis in the right side of the abdomen extending to the upper part of the right thigh. There is slight edema in the lower legs.

The body is opened through a Y incision. There is localized peritonitis in the operated area and in the right side of the abdomen. There are marked adhesions between the right lung and the pleural layer covering the right hemidiaphragm.

Urinary system: The left kidney and left ureter are absent.

On the right side there is a mass covering the right kidney measuring 20 by 12 cm. which is a hematoma under the peritoneum. The artery and the vein of the right kidney are larger than normal.

Right kidney weighs 350 grams and there is dark area measuring 1.5 cm. in diameter on the posterior surface near the lower pole and blood clots sticking to this area and extending all over around the kidney and capsule. Section of the kidney shows a lesion in the cortex of the kidney, similar to an infarction, which had ruptured and bled recently.

Pathological Diagnosis:—*Right lung:* Congestion and atelectasis; —*Liver:* Cavernous hemangioma; —*Genitourinary system:* Right kidney: Ruptured cavernous hemangioma; Toxic nephrosis; Hypertrophy. —Left Kidney: Congenital absent.

Summary

1. Renal hemangioma is a very rare disease.

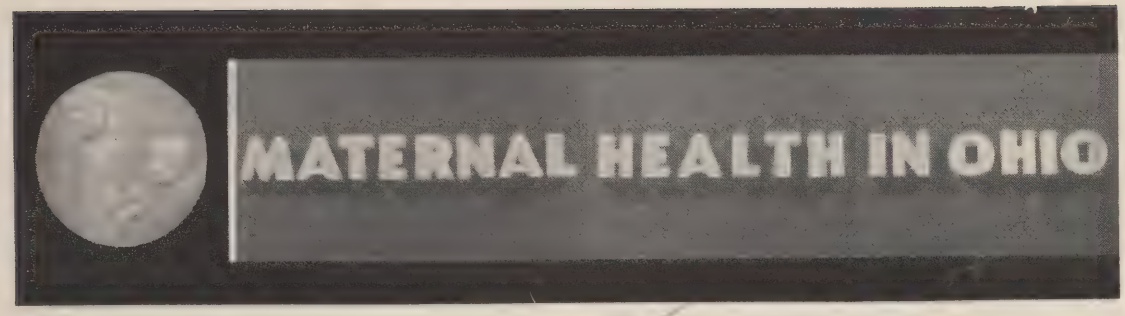
2. We have here reported what appears to be the eightieth case in medical literature of the whole world, and this one is unique in that it is the first case reported in the literature of renal hemangioma with the agenesis of the other kidney. In addition, this case of hemangioma of the kidney concomitant with hemangioma of the liver, is the second case of kidney hemangioma with hemangioma of elsewhere, reported in the literature. The site, cortex, and the size, 1.5 cm., make it even more unusual.

3. From the clinical point of view the case is unusual because of the right side abdominal sharp pain due to retroperitoneal hemorrhage and associated shock, possibly due to the combination of renin released from the kidney with renin activator.

4. In every emergency nephrectomy an intravenous phenolsulfonphthalein test should be made to determine the condition and value of the other kidney.

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Case No. 2

This patient, a 35 year old white, Para VI, died three and one-half hours postpartum. Her past history was essentially negative. She had had five spontaneous deliveries of living children prior to the last pregnancy. With a last menstrual period April 9, her prenatal care was adequate except perhaps during the final weeks. Her blood pressure was found to be normal; urine examinations and serologic test for syphilis, were negative. She developed hypertension (systolic 165 - 185, diastolic 110) and pedal edema during the last two weeks of her gestation.

At term she was admitted to the hospital on January 6 at 7:20 p. m., apparently in labor. She was found to have evidence of a toxemia, namely pedal edema and a blood pressure of 185/110. The labor which had started spontaneously was characterized by strong contractions at five minute intervals. After but two hours and 30 minutes she spontaneously delivered an eight pound, two ounce, baby. The placenta was delivered complete after five minutes. She had no laceration and received no analgesia or anesthesia. Pituitrin® and ergotrate were administered intramuscularly and after about one-half hour she was moved to her room.

While in transit from the litter to her bed she complained of severe pain in the chest and upper abdomen, the latter simulating "indigestion." This was followed shortly by severe cramp-like pains in both hands and in her back. She became apprehensive. Her pressure which had been high dropped to 100/65 and her pulse became thready. Her bleeding was not apparently excessive, but the pressure continued to drop. An intravenous solution of glucose and ephedrine was given in an effort to combat her shock; she received morphine for pain. Oxygen was administered. Three and one-half hours following delivery she expired.

Autopsy permission was granted.

Cause of Death: Coronary thrombosis; toxemia of pregnancy; parturition was listed as a contributing factor.

Pathological Diagnosis: Infarction of the myocardium due to arteriosclerotic coronary thrombosis; pulmonary tuberculosis healed; generalized arteriosclerosis; cholangitis; acute appendicitis.

Comment

The Committee voted this a nonpreventable maternal death with pregnancy and labor indirectly the causative factor. However, members criticized the failure to take some definite action relative to her edema and hypertension in the last two weeks of gestation; the use of pituitrin and ergotrate in the presence of a hypertension; and the lack of elementary laboratory studies on a patient with toxemia.

TOPIC THIS MONTH:

Maternal Deaths* Involving Cardiac Disease

Case No. 38

This patient, a 19 year old white, Para I, abortus I, died less than one hour following delivery. Her past history was significant in that she had a history of rheumatic fever in childhood with no manifest sequelae. She had been pregnant once previously but aborted in the third month. The prenatal course was complicated by scant bleeding in the first trimester and dependent edema in the last two months. Her care in the hospital clinic was adequate and included diet and salt restriction. Report of her physical examination, however, failed to disclose any obvious cardiac lesion. She had several bouts of false labor; last menstrual date not reported.

On May 9, at 7 p. m., she was admitted to the hospital (presumably at term) one-half hour after the onset of labor. Her contractions occurred at three minute intervals and lasted 40 seconds; blood pressure was 150/90. She was found to be 5 cm. dilated, the head in a left occipitoanterior position with the vertex at -2 station. There is no record of examination of her heart and lungs. She was given Demerol® 100 mg. and scopolamine .0004 mg. for analgesia at 7:30 p. m. Full dilation was attained at 9:10 p. m. and the head crowned at 10 p. m.

The patient was transferred to the delivery room and vomited on arrival. Immediately she became dyspneic and cyanotic. By 10:30 p. m. her heart sounds were normal but her lungs were full of moist rales. The attending clinic physician arrived and, assisted by the intern on service, quickly performed a low forceps delivery over an episiotomy made under local infiltration with Novocain.® Without waiting for delivery of the placenta, a bronchoscopy was done, which revealed frothy, bloody material but no evidence of gastric contents. She was given morphine and Cedilanid® intravenously but expired at 11:35 p. m., May 9.

The baby, a seven pound boy, left the hospital on the ninth day in good condition. Autopsy permission was granted.

Cause of Death: Cardiac failure, rheumatic heart disease, pregnancy at term delivered.

Pathological Diagnosis: (1) Acute myocardial fail-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

ure, postpartum. (2) Severe congestion and edema—all organs.

Comment

The Committee felt that this case, while presumably one of cardiac failure, did not completely satisfy all the requisites for such a classification. It was true the patient had a history of rheumatic heart disease, yet she apparently had neither a demonstrable cardiac lesion or a history suggestive of myocardial weakness.

The Committee reviewed the facts available, accepted the pathological diagnosis of acute myocardial failure, and voted the case a nonpreventable maternal death, by a narrow majority. Yet one cannot help but speculate that some embolic phenomenon might have precipitated that failure. It is also possible that some features and events in the case were not recorded.

Case No. 143

This patient was a 40 year old white, gravida VI, Para V, who died undelivered at 28 weeks gestation. The available prenatal history was meager, although she was attended by a physician who presumably gave her adequate care, including two periods of hospitalization for dyspnea, the last in October, at about four months gestation. She was a known cardiac who had been in cardiac failure during her previous pregnancy six years before.

In her seventh month she was admitted to the hospital again on January 25, showing signs of cardiac failure as manifested by shortness of breath, "congestion" of the lungs and signs of mitral disease. She failed to respond to bed rest and other efforts to relieve her cardiac distress. Details of her therapy and studies are not available. Her course progressed downhill and she expired undelivered on January 27. Autopsy was permitted.

Cause of Death: Rheumatic heart disease with grade 4 cardiac failure; pregnancy, duration seven months.

Pathological Diagnosis: Healed endocarditis; stenosis and calcification of the mitral valve; pulmonary edema; chronic passive congestion of liver and spleen; uterine pregnancy at seven months.

Comment

From her story of cardiac failure in her previous pregnancy, this patient could have been classified as a severe or "class 4 cardiac." She already had five children and the Committee raised the question as to the advisability of permitting her to embark on another pregnancy. Should she have had a commissurotomy prior to undertaking the last gestation? With an unchanged cardiac status should the gestation have been interrupted at the time of her first hospital admission, in the first trimester of the last pregnancy?

On a basis of the data submitted, the Committee voted this a nonpreventable maternal death, but it felt that the ruling could be altered on the basis of the points previously noted, if more complete information were available.

Comment of Consultant

The following comment of a consultant who is a specialist in cardiology, was given at the request of the Committee.

With regard to **Case No. 2** one cannot be sure that pregnancy and labor indirectly caused the myocardial infarction because such episodes frequently occur at rest and even during sleep. No suspicion of coronary disease or other arteriosclerosis can be gleaned from the history and physical examination and one is a little reluctant to believe that a blood pressure of 185/110 for two weeks brought on arteriosclerosis. Therefore I would disagree that the taking of more definite action referable to the hypertension may be subject to censure. Furthermore, there was no clinical evidence of a weakened myocardium and I would not quarrel with the glucose infusion because it seems that this was given in an effort to get a pressor agent into the patient. Ephedrine is not a very effective pressor so that one can wonder why more effective ones such as Neosynephrine® or nor-epinephrine weren't used. Pituitrin® and perhaps ergotrate, it seems, are not good in the face of hypertension because of the possibility of a further increase in an already elevated peripheral resistance with a further increase in pressure.

Case No. 38 is confusing, especially the pathologic diagnosis of acute myocardial failure without mention of organic heart disease or cardiomegaly. One can't help but wonder if the speculation of embolic phenomena raised by the Committee might not be correct because of the sudden onset and extremely rapid course plus the lack of symptoms of failure during the antepartum period. One also could speculate about the occurrence of that vague, poorly understood entity postpartum myocardosis although this seems to be quite early post partum. The only further therapeutic suggestion would have been a 400 to 500 cc. phlebotomy, in addition to what was done. If there had been time, spinal anesthesia would have accomplished the same end, namely decreasing the venous return to the heart.

Regarding **Case No. 143**, I would agree that this patient was a moderately severe cardiac who probably should not have been permitted to become pregnant the last time. In addition she had two episodes of dyspnea in the first trimester of the last pregnancy, so that it could have and should have been interrupted. Conceivably this patient might have benefited from mitral commissurotomy. This is purely speculation. The anatomical description of the mitral valve would put this patient into that group which derives the greatest benefit from surgery.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 71 year old white female entered the University Hospital, Columbus, with complaints of multiple arthritis of 18 years' duration. She had apparently been in good health until 18 years ago, when she rather gradually developed pain in both shoulders, wrists and the metacarpophalangeal and interphalangeal joints of the hands. She was told by her physician that she had arthritis and was treated with salicylates and Darthronol®, a vitamin D preparation. From the onset of her arthritis, except for two years during which she was free of symptoms, she took 1 to 6 capsules of Darthronol daily. Two years prior to admission she was started on 5 mg. of prednisone three times a day, which she had been taking regularly up to the time of admission. Her vitamin D intake was decreased to 1 capsule daily for the past year.

Three years ago she noted nodules appearing on her hands, fingers and on the left foot. These increased progressively in size and number but caused little pain. She was hospitalized in Colorado three years ago for severe low back pains. She was told that she had too little calcium and was treated with steroid therapy. A question of diabetes was also raised at that time. The past history included a cholecystectomy 30 years prior to admission. Review of systems revealed nocturia two or three times nightly and psoriasis of the elbows and legs for many years.

Physical Examination

Her blood pressure on admission was 155 over 88, her pulse 88, her respirations 20, and her body temperature 99.0°F. The patient was a well developed, somewhat undernourished white female who appeared chronically ill and walked with a decided limp. There was a scaly erythematous rash over both elbows, the back, and on both legs which had the typical appearance of psoriasis. The fingernails were pitted. Examination of the eyes revealed a Grade 2 hypertensive retinopathy. The heart was not enlarged but a Grade 3 systolic murmur could be heard over the apex and a Grade 1 systolic murmur over the arota. There was slight left costovertebral angle tenderness.

Her extremities showed marked deformities of both hands with flexion contractures of the fingers of both hands as well as multiple large nodules close to the interphalangeal joints and in the dorsums of the wrists. These nodules were soft and non-tender. The skin was not reddened over them. On the back of the left hand there was a 5 by 5 cm. soft cystic swelling over the fifth metacarpal. There were also large nodules on the left foot over the first metatarsal and deeper, smaller ones over the dorsum of the left foot.

Presented by

- **William D. Robinson, M. D., University of Michigan,**
- **John W. Sigler, M. D., Henry Ford Hospital, Detroit, Michigan, and**
- **Emmerich von Haam, M. D., Ohio State University. Edited by Dr. von Haam.**

Laboratory Data

Her red blood count was 3.47 million, the hemoglobin 9.8 Gm.; her admission white blood cell count was 7,900; the differential count showed 13 per cent nonsegmented forms, 29 per cent segmented and 52 per cent lymphocytes. The sedimentation rate was consistently elevated (39 mm. in an hour corrected). The serological tests for syphilis were negative.

Urinalysis showed 20 mg. of protein with 2 to 3 white blood cells and 4 to 5 red blood cells per high power field. The total serum proteins were 6.9 Gm. with 4.1 Gm. of albumin and 2.8 Gm. globulin. The serum amylase was 338 units; the serum sodium was 136 mEq., the potassium 3.9 mEq., and the serum chloride 99 mEq. The inorganic phosphorus of the serum was 4.3 mg., the alkaline phosphatase was 5.1 units; the serum calcium was 12.4 mg. The Sulkowitch reaction for calcium in the urine was 1 plus, 0 and 3 plus on three occasions. The blood urea nitrogen was 38 mg. The whole blood uric acid was 5.6 mg., and the serum uric acid 8.0 mg.

The 24-hour excretion of uric acid in the urine ranged from 0.29 Gm. to 0.72 Gm. for 10 successive days. The urinary xanthine for 24 hours during the same period ranged from 0.75 mg. to

4.91 per total volume. The drop-latex fixation test was negative on two occasions and positive in a dilution of 1:40 on the third. Examination of fluid aspirated from the cystic nodule gave a negative murexide test for uric acid and a positive test for protein; the uric acid content of the tophus fluid was 8.8 mg., the total urates 9 mg.; the calcium content was 1660 mg. The catheterized urine specimen revealed no organisms.

The pathologic diagnosis of a specimen obtained from the suprapatellar bursa by needle biopsy was "joint mice." The stain for uric acid was negative. The electrocardiogram was normal.

Roentgenographic Examination

X-ray examination of both hands, elbows, knees ankles and feet showed striking multiple, well-defined, large and small calcifications scattered throughout the soft tissues of the periarticular regions. Radiologic examination of the dorsal and lumbar spine showed osteophytosis of the vertebral bodies and marked calcification of the aortic arch. A flat plate of the abdomen showed in addition to generalized osteoporosis, dense amorphous calcium deposits in the soft tissue of the left hip and multiple small but dense calcifications overlying each kidney. An intravenous pyelogram revealed prompt excretion by both kidneys after 5 minutes, but only the kidney pelves visualized satisfactorily. From this it was concluded that the patient suffered from bilateral nephrolithiasis with poorly visualized upper urinary drainage.

Hospital Course

Various observers believed the patient had gouty arthritis, "chalk gout," hypervitaminosis D, and rheumatoid arthritis. One week after admission the patient developed an acutely swollen, purplish red, tender first metatarsophalangeal joint of the right foot. She was started on colchicine but developed nausea after a dose of 8 mg. and the drug was discontinued. The pain in the toe disappeared and most of the swelling was also gone by the following day.

Thereafter she was given 5 mg. of prednisone twice a day, 0.6 Gm. of aspirin four times a day, and 0.5 mg. colchicine three times a day. She made consistent improvement. Because of nausea after colchicine the dosage was reduced to 1.0 mg. at bedtime. She was discharged after a hospital stay of a month, on 1 mg. of colchicine at bedtime and 0.5 Gm. of Benemid® daily.

Two weeks after discharge the patient was readmitted, to the Surgical Service, with the chief complaint of acute epigastric colicky pain of one day's duration. She became distended, nauseated, vomited several times and was unable to retain fluid. Auscultation revealed rushes and upper peristalsis was noted. The pain was referred to the upper abdomen with tenderness to palpation of the epigastrium. An x-ray examination revealed a dilated ascending and transverse colon but no evidence of obstruction. The serum amylase was 700 units. A peritoneal tap revealed no free fluid.

She was treated with constant nasal gastric suction, anticholinergics, sedation, serum albumin and whole blood. The serum amylase remained elevated for about one week; however, it continued to decline and the last test before her death showed only 178 units. On the seventh hospital day the patient developed an irregular pulse which on an electrocardiogram proved to be a paroxysmal auricular tachycardia. She was digitalized and within 24 hours the rate returned to normal. Two days later the patient was found on the bedpan gasping for air. She became cyanotic and expired.

Clinical Discussion

DR. F. W. MCCOY: We have with us today Dr. William Robinson from the University of Michigan and Dr. John Sigler from the Henry Ford Hospital in Detroit. I believe that Dr. Robinson is going to start the discussion.

DR. W. D. ROBINSON: The problem which this patient presents is a complicated one and must be considered from several aspects.

In essence, we have a 71 year old woman who had had some form of chronic joint disease since the age of 53. We also know that this woman had been taking two medications for a long time which could have had quite marked effects on her body as a whole, as well as on her joint disease. I would estimate that she took about 300,000 International Units of vitamin D a day for an unspecified period, apparently starting shortly after the onset and continuing for a matter of 17 to 18 years, which had been reduced only in the year prior to her admission. We also know that for a period of two years prior to admission she had been taking prednisone, a potent adrenocortical steroid, in quantities of 15 mg. a day, which dose will induce in the average person some degree of clinically detectable hyperadrenalism.

Approximately three years before she was first seen here she developed periarticular and paraarticular nodules which showed some very real peculiarities. She was readmitted with the picture of an acute abdominal emergency and died rather suddenly following an episode of cardiac irregularity. The cause of death, the question of its relationship to her cardiac status and the acute abdomen as well as to her primary disease and

to her medications are all problems that we will have to discuss. Rather than taking this patient's difficulties in chronological order, I would like to start my discussion with what I consider the more certain facts and then go to the more tenuous aspects.

I think we can be reasonably certain that this patient suffered from a severe degree of chronic vitamin D intoxication. After 18 years of joint disease her hands showed the presence of definite nodulation over the proximal interphalangeal joints of the fingers and the metacarpophalangeal joints. You can't tell from the film to what extent these were cystic and to what extent they appeared to be solid, but they are very real. It is difficult to appraise the condition in the joints, but one gets the impression that there was not a great deal of synovial swelling and that most of the enlargement of the joint area was related to the nodulation.

The amazing and striking thing is the tremendous amount of soft tissue calcification in the para-articular regions, which calcifications corresponded to some extent to the distribution of the nodes present in the hands. The cartilage at some of these metacarpophalangeal joints was still preserved, but there seemed some serious destruction of the joints of the wrist which was obscured by the soft tissue calcifications. The x-rays of the feet also showed tremendous depositions in the metatarsal areas and the anterior tibial tendon.

Rheumatoid Arthritis?

Dr. J. W. Sigler: Some of the changes in the proximal phalangeal joints could be on the basis of degenerative joint disease, but the films are so obscured by calcification that it is difficult to see whether they represent a true picture of rheumatoid arthritis. If all this tumefaction was due to gout, we would expect to see some real osseous tophi. This discrepancy between the soft tissue calcification and the absence of osseous tophi would be most unusual if this was all a matter of gout, and in gout with soft tissue tumefaction you may get shadows due to the urate deposition in association with calcium, but you don't get this degree of hard calcium deposition.

Dr. Elson: From her x-rays I think she did have preëxisting arthritis. Her demineralization would be compatible with rheumatoid disease, but she was getting vitamin D and that too would tend to mobilize the calcium from her bones. We have some trouble differentiating between the changes in gout and in rheumatoid arthritis, but I lean more toward rheumatoid arthritis in this patient. However, it does not appear that she had a lot of joint disease. Her hip joint as well as her elbow showed only slight evidence of degenerative osteoarthritis in spite of all the severe soft tissue calcification.

Dr. Robinson: Since this patient had psoriasis the possibility of psoriatic arthritis should be given some consideration, especially since she also had the pitting of the fingernails so characteristic of this disease. However, if there is anything distinctive about so-called psoriatic arthritis to differentiate it from ordinary rheumatoid arthritis, it is the involvement of terminal interphalangeal joints, and certainly we are not impressed that there were any changes in her terminal interphalangeal joints.

Vitamin D Intoxication

Vitamin D intoxication produces a series of manifestations that are quite variable from one individual to another. The dose which can be tolerated without toxicity varies a good deal. The most common manifestations are polyuria and gastrointestinal complaints. Mental and neurological symptoms such as headache or depression may also occur, and I have seen one patient with vitamin D intoxication who suffered convulsions. Most of the symptoms, particularly the chronic ones, are related to hypercalcemia and refer to renal lesions. The routine urine analysis may not show significant abnormalities. However, the nonprotein nitrogen or blood urea nitrogen may be elevated and there frequently exists an anemia such as was found in this particular patient.

Blood Calcium 12.4

The patient's significant chemical finding was a blood calcium of 12.4, which is definitely elevated by most methods and standards. I think that the duration of elevation of serum calcium rather than its magnitude was perhaps an important factor in this patient. The alkaline phosphatase is usually normal or slightly elevated. The inorganic phosphorus is usually elevated and its increase usually parallels the degree of renal damage as expressed by the blood urea nitrogen, such as was the case in this patient. Extensive soft tissue calcifications in the para-articular regions, the blood vessels, the kidneys and in almost all tissues including the pancreas complete the picture.

A finding somewhat less common in patients with vitamin D intoxication is the development of periarticular cysts, which I think could explain all the tumefactions in this patient. These cysts develop in relationship to joints and on microscopic examination are distinctly different from typical rheumatoid nodules. Therefore I think that the nodular lesions which developed in our patient around her joints can well be attributed to the vitamin D intoxication, which must have been

rather marked in degree as far as the history suggests. I do not think that they are gout tophi or rheumatoid nodules.

The question of her primary joint disease—and I think this patient had primary joint disease—is not quite as easy to be certain about, and here the problem of differentiation between gout and rheumatoid arthritis may be a very real one. While we can explain the lumps and bumps this patient had on the basis of vitamin D intoxication, just how seriously would we take the possibility of gout if she had not had any lumps or bumps? If we omit the tophi, the diagnosis of gout can be established on the basis of three important criteria: the clinical behavior, the presence of an elevated serum uric acid, and the response of the acute attack to colchicine.

The characteristic story of gout is the occurrence of acute attacks lasting usually three to seven days with completely symptom-free intervals of six months to a couple of years and complete subsidence of any joint lesions between the acute attacks. As time goes on, the acute attacks last somewhat longer and become somewhat more frequent, and after 5 to 10 years the patient develops residual joint lesions between attacks, the so-called gouty arthritis. In contrast to this, patients with rheumatoid arthritis develop residual joint lesions quite early in the course of the disease and do not have the long symptom-free intervals.

Importance of History

For this reason it is extremely important to sit down with the patient and say, "Tell me exactly what happened the first time you had any trouble with your joints," and from the clinical history we can make the diagnosis often much more easily than from the examination of the joints. The information you can get relative to the first joint manifestations is extremely helpful. In our patient the onset was rather gradual, initially involving only one wrist and gradually becoming polyarticular and persisting throughout. There were no remissions in the activity of her joint disease except for one period of a year.

However, to further complicate the picture our patient had what we certainly must accept as a hyperuratemia. The upper limit of normal serum uric acid by most methods is about 6 mg. per 100 ml. for men and about 5 mg. for women. A value of 8 mg. per 100 ml. uric acid in her serum represents definite hyperuratemia. Hyperuratemia is certainly not diagnostic of gout and we have to consider other conditions which might increase the serum uric acid. The first that comes to my mind are some of the blood dyscrasias— polycythemia, the leukemias—which the patient did not have.

Second, renal disease, in which the uric acid may be elevated along with the nonprotein nitrogen and the blood urea nitrogen. It is my impression that the degree of elevation of her serum uric acid is somewhat disproportionate to her elevated blood urea nitrogen. The determination of uric acid excretion in the urine does not help us particularly, because normal individuals and most patients with gout will excrete somewhere between 300 and 600, possibly 700 mg., of uric acid per 24 hours if they are put on a low purine diet. Anybody who has experience with gout patients sooner or later finds that every fifth or sixth patient is a high urate excreter, but certainly no more than 20 per cent of them will excrete up in the range of a gram or a gram and a half on a low purine diet.

Concerning the third diagnostic criterion, the matter of the response to colchicine: We did have an episode observed in the hospital when the patient developed acute pain in the toe, which is the proper place for an attack of gout, with very definite swelling which subsided after a total dose of 8 mg. of colchicine.

X-Rays

From the x-ray picture, as we pointed out, the joint lesions appear to have more the appearance of rheumatoid arthritis than of gout. However, some of the laboratory findings and the single observation concerning the response to colchicine are suggestive of gout, while the clinical history and the roentgenographic findings are more suggestive of rheumatoid arthritis. I personally feel that most likely this patient's underlying joint disease was rheumatoid arthritis in spite of the laboratory findings, partly because it is my general philosophy that when the laboratory and clinical findings don't agree, it is better to treat the patient rather than the laboratory findings. However, I don't think we can be certain of this.

If this is gout, I still think that the paraarticular tumefactions developed largely on the basis of vitamin D intoxication rather than on the basis of tophi because of the absence of osseous tophi in the presence of such extensive soft tissue lesions. Of course, again this is a problem in which the pathologist can be extremely helpful, because a biopsy of these nodules at the time of first admission could have quite clearly settled the question of whether one was dealing with rheumatoid arthritis with tophi of gout or with vitamin D intoxication. I think perhaps I should let Dr. Sigler continue the discussion as far as the terminal phase of the patient is concerned—

the acute abdominal emergency which brought the patient back to the hospital.

DR. SIGLER: In the differential diagnosis of her final illness a ruptured viscus and a perforated ulcer must be considered first. I am sure that x-rays were taken in order to rule out the presence of free air under the diaphragm, and we know that a peritoneal tap did not yield any fluid. This speaks against a diffuse peritonitis which we would expect from the previously mentioned lesions and also against a diverticulitis, which is something we should always think of in a person of this age who develops abdominal symptoms, particularly if the patient has been on steroid therapy. I don't think that this complication was due to steroid therapy, but the steroid therapy may have masked the usual severity of a peritoneal reaction.

Her Age Group

In this age group we also always have to consider mesenteric thrombosis, but most of the evidence obtained during the last hospitalization of the patient points toward a pancreatitis, and her elevated serum amylase seems an important and significant criterion in this respect. I would just like to mention that a disarrangement of the acinar pattern of the pancreas with focal fat necrosis has been described recently in patients who have been receiving steroid therapy. None of these patients had any clinical manifestations of any pancreatic disease. Furthermore I don't think we can overlook the fact that vitamin D intoxication might also produce pancreatitis-like lesions since calcium deposits in the acini and calcium concretions in the ducts may lead to obstruction of the flow of pancreatic enzymes and cause pancreatitis.

I feel reasonably certain that this patient suffered from vitamin D intoxication with the principal manifestations of periarticular calcium deposits and renal calcinosis. I believe with somewhat less confidence that her primary joint disease was rheumatoid arthritis. I would not be too surprised if it would turn out to be gout, although the odds seem strongly against it.

I do not think we can be as certain about her terminal illness, although I would certainly put pancreatitis at the top of the list with perhaps mesenteric thrombosis next and diverticulitis or a ruptured, slowly leaking viscus as an outside possibility. I would like to know how she got along with her treatment during her last hospitalization, which certainly would influence our opinion as to whether the abdominal lesion was the direct cause of death or whether she might have died a cardiac death. Did she respond pretty well to the treatment she was getting?

DR. PHILIPS: She expired rapidly but the abdominal complaints seemed to improve before her death.

DR. SIGLER: After hearing Dr. Robinson, you can see what a problem it is to follow him in discussing any case. I feel much the same as Dr. Robinson that this patient in all probability had a rheumatoid arthritis although I think that we would have to agree that because of her renal damage the patient probably had an attack of gout secondary to the degree of renal damage. It is difficult to say that a patient does not have gout when you get a response to colchicine. I would like to ask a few questions. I presume that an electrocardiogram was made at the time of this patient's last admission?

EKG

DR. PHILIPS: The electrocardiograms previous to her terminal illness had been normal. An EKG taken at the time she became cyanotic and showed air hunger revealed only a paroxysmal auricular tachycardia.

DR. SIGLER: We know of course that patients with hypercalcemia have an abnormal Q-T ratio and are a little more sensitive to digitalis. I understand that the patient did not receive any more steroids at the time of her last admission. Since she had been on steroid therapy for a long time, we can assume that her own adrenals were probably hypoactive at the time of her acute illness and not able to control the stress produced by her acute pancreatitis. Thus I think that the possibility of death due to acute adrenal insufficiency should be considered. Finally, because of the tremendous disturbance in her calcium metabolism we can also speculate that the patient suffered from secondary hyperparathyroidism.

I would like to close by saying that I pretty much agree with what Dr. Robinson told you. I feel that the patient did have rheumatoid arthritis and also some degenerative joint disease, which of course had little bearing on her demise. I also believe that the patient developed gout secondary to her renal lesions. Certainly by far the most important part of her illness was the vitamin D intoxication with extensive calcinosis.

I feel that the cause of her death was an acute pancreatitis with the possibility of acute adrenal insufficiency contributing to her sudden demise. I don't think that we can completely rule out a ruptured viscus or a perforated ulcer. Lastly, I

would not like to rule out completely the possibility that this patient had superimposed hyperparathyroidism.

Clinical Diagnosis

1. Chronic vitamin D intoxication.
2. Rheumatoid arthritis.
3. Nephrogenic gout.
4. Acute pancreatitis.
5. Acute adrenal insufficiency.
6. Secondary hyperparathyroidism.
7. Psoriasis.

Pathological Diagnosis

1. Chronic vitamin D intoxication.
2. Nephrocalcinosis with nephrolithiasis.
3. Acute pancreatitis.
4. Recent myocardial infarction.
5. Psoriasis.

Pathological Discussion

Dr. von Haam: Gentlemen, you have heard a very, very instructive discussion and in some respects the pathological discussion will be disappointing because of the restrictions which were placed upon us in performing the autopsy, preventing an exploration of her diseased joints. However, we could study some of the periarticular nodulations microscopically and must presume that all showed an identical picture.

The body was that of an obese elderly female. The joints of the hands, wrists and feet showed extensive periarticular nodulations which were either solidly calcified or appeared cystic and contained thick, gray, paste-like material. Her skin showed scaly psoriasis. The abdominal cavity contained about 200 cc. of clear fluid.

The heart was slightly enlarged and showed slight calcium deposits at the base of the aortic cusps. The lateral wall of the left ventricle contained an area of red softening with myocardial hemorrhage measuring 2 by 2 cm. The principal coronary vessels appeared arteriosclerotic and their lumens appeared narrowed but no occlusion could be demonstrated.

The lungs, spleen and liver appeared grossly normal. The pancreas was discolored and edematous. The peripancreatic fat contained many typical yellow-white specks of fat necrosis. The organ was swollen, soft and appeared rather hemorrhagic. The gastrointestinal tract appeared normal. The adrenals had a combined weight of only 9 grams but appeared grossly normal. The kidneys were nodular with superficial scarring. The pelves contained much sand and small greenish brown stones. The remaining organs including the brain appeared grossly normal.

Microscopic Examination

Sections through the heart revealed a recent infarction with interstitial hemorrhage and barely perceptible changes in the myocardial fibrils. We estimate the duration of the infarct at between one-half and two hours. Other sections showed some myocardial fibrosis and calcific aortic sclerosis. The lungs appeared normal. The liver showed a mild chronic cholangitis. Sections through the pancreas showed marked dilatation of the ducts, which appeared filled with large structureless hyaline material. There was extensive recent necrosis of acinar tissue with interstitial inflammation and widespread fat necrosis. Sections through the adrenals showed cortical lipid depletion.

Microscopic examination of her kidneys revealed extensive acute and chronic pyelonephritis with numerous calcium casts and deposition of calcium in the interstitial tissue. Examination of the parathyroid glands failed to demonstrate any hyperactivity of the glands. Microscopic sections through the excised periarticular nodes failed to show any evidence of uric acid deposits as is so typical of gout tophi. Instead the nodes consisted of hyaline fibrous tissue with extensive calcium deposits and small foci of still active granulation tissue. I considered them as calcium deposits in degenerated and hyalinized fibrous tissue such as occur in the soft periarticular tissue of rheumatoid arthritis, although the latter could not be confirmed at autopsy.

Summarization

In conclusion, I feel that the patient suffered indeed from vitamin D intoxication with widespread calcium deposits in the soft periarticular tissues and the kidneys. Of all metabolic diseases with metastatic calcification—the one following osteomalacia, renal disease, parathyroid disease and vitamin D intoxication—the latter shows the least diffuse distribution of metastatic calcium deposits. In this condition calcium is rather deposited in degenerated or diseased tissues and our patient also failed to show metastatic calcification at the usual places—the lungs and blood vessels.

I do not think that the patient had gout. Her severe nephrocalcinosis, also a consequence of her vitamin D intoxication, had led to increasing renal insufficiency as proven by her post-mortem blood urea nitrogen of 58 mg. per 100 ml. The final illness of the patient was acute pancreatitis as we find to occur in vitamin D intoxication as well as in patients on prolonged steroid therapy. This

inflammatory process of the pancreas then was the trigger mechanism for her acute myocardial infarct, which I consider the immediate cause of death. Any comments, Dr. Robinson?

DR. ROBINSON: I am particularly impressed with the severe interstitial calcification of her kidneys and the way the calcium is deposited in the connective tissue and in the kidney parenchyma and not in the walls of the blood vessels, which is so frequently seen in vitamin D intoxication. I am certainly satisfied that the periarticular nodularities are not tophi which had secondarily calcified from the vitamin D. Under such circumstances you certainly would have seen some urate crystals and more of a giant cell type of reaction, as in a real gout granuloma.

On the other hand, as Dr. Sigler pointed out, the possibility of a secondary gout is not completely ruled out by the absence of deposition of uric acid in the soft tissue. I think, however, that it is most unlikely, particularly since gout in a woman is such an unusual disease.

Treatment of Emergencies In Allergy

The chief need in status asthmaticus, after breaking contact with the allergen, is to correct hypoxemia and, in advanced cases, hypercapnia. To accomplish this improvement in gas exchange intensive aerosol therapy with adrenergic amines is indicated, aminophylline by rectum or by vein being another useful bronchospasmolytic agent. Either can be effectively combined with intermittent positive pressure breathing in inspiration, using air or oxygen.

Intermittent positive pressure breathing is especially suited to the patient who is exhausted or who exhibits depression of the respiratory centers. Overt infection calls for effective antibiotics, the failing heart for digitalization, and trapped bronchial secretions for tracheotomy when conservative means of evacuation prove unsuccessful.

Although opiates and barbiturates may provide much needed sleep, this advantage is outweighed by a resulting depression of the respiratory centers, of the cough reflex, and of bronchial ciliary action. ACTH as well as the natural and the prednisteroids will provide dramatic relief of symptoms, particularly if a product like prednisolone is employed intravascularly.

The risks and contraindications must, of course, be given full consideration. The importance of restoring normal fluid and electrolyte balance and of supporting the asthmatic patient's confidence is too obvious to discuss.—Mary Hewitt Loveless, M. D., New York City: *New York State J. Med.*, 57:3797, December 1, 1957.

Selective Readings . . .

The Diminished Mind, A Study of Planned Mediocrity in our Public Schools, by Mortimer Smith. ($2.75. *Henry Regnery Co., Chicago 4, Ill.)* The author of **And Madly Teach** has given us a closely reasoned and well documented book in support of the thesis that learning, in the traditional sense of disciplined knowledge, is rapidly declining in our public schools. This decline is not by chance, but by deliberate—and almost invariably well-intentioned—design of those responsible for setting the direction of public education.

The author shows that schoolmen today look upon genuine education as a luxury for all intellectual elite while the majority, they believe, will have to be content with courses in vocational training or "adjustments." This current contempt for intelligence leads, he insists, not only to adulteration of learning, but sometimes attempts the educator to try and manipulate the minds under their charge. In doing this, he devotes a chapter to the numerically small, but extremely active, group in education known as "Social Reconstructionists" who believe frankly that the task of schools today is to indoctrinate for a new social order (their own, of course). Written with a wry humor, this book is essentially a serious indictment of public education and, incidentally, a plea to those who believe in the public schools to rescue them from the rigid bureaucratic control of the professional educators.

Stress, the fifth annual report 1955-56, edited by Hans Selye and Gunnar Heuser. ($20.00. *M. D. Publications, Inc., 30 E. 60th Street, New York 22, New York.)* These annual volumes are published to act as guides for the entire literature on stress. They correlate pertinent facts that are not in any way related to the subjects that bring the concept up to 1955 by a summary of the research of the general Physiology and Pathology of exposure to this factor and outlines all principal problems beginning by investigations at the present time. The place that the adaption syndrome of Selye has come to occupy makes medical references to this work obligatory upon all who are interested in the mechanism of diseases.

Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey, by O. W. Anderson and Jacob J. Feldman. ($6.50. *McGraw-Hill Book Co., New York 36, N. Y.)* This is the first nationwide survey on family medical costs since 1933. It stands as a definitive source book based on new data from interviews done by men from the Health Information Foundation and the National Opinion Research Center.



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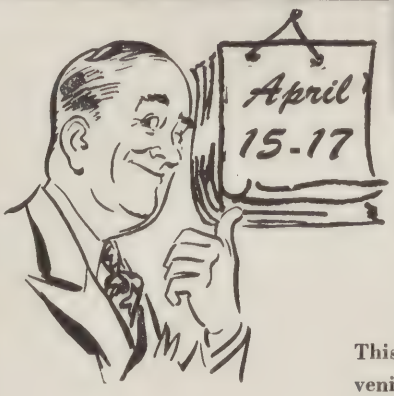
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Hospital Pharmacy or Drug Room . . .

Joint Commission on Accreditation Points Out the Importance of This Department in the Maintenance of a High Quality of Patient Care

IN keeping with its aim of assisting hospitals to meet and exceed minimal standards of high quality patient care, the Joint Commission on Accreditation of Hospitals stresses the importance of three departments in the institution—the pharmacy or drug room, the dietary department and the emergency room. This article is devoted to the pharmacy or drug room. Subsequent articles will report the Commission's recommendations in regard to the dietary department and the emergency room.

The Standards of the Joint Commission on Accreditation of Hospitals in regard to the pharmacy or drug room are quoted below.

a. There shall be a pharmacy directed by a registered pharmacist or drug room under competent supervision.

b. Facilities shall be provided for the storage, safeguarding, preparation, and dispensing of drugs.

c. Personnel competent in their respective duties shall be provided in keeping with the size and activity of the department.

d. Records shall be kept of the transactions of the pharmacy, and correlated with other hospital records where indicated. Such special records shall be kept as are required by law.

e. Drugs dispensed shall meet the standards established by the United States Pharmacopeia, National Formulary, New and Non-official Remedies, British Pharmacopeia, or Canadian Formulary.

f. There shall be an automatic stop-order on dangerous drugs.

Of the above, 'a' and 'f' are sometimes not well understood. The hospital which cannot obtain or afford a hospital pharmacist should try and obtain the services of one on a part-time or consultative basis. If the hospital pharmacist of another hospital is not obtainable in this capacity, then the services of a local pharmacist should be utilized wherever possible. With his help the correct procedures, rules and regulations for this department should be drawn up.

The requirement of an automatic stop-order on dangerous drugs is misunderstood frequently by hospitals and physicians. The Joint Commission on Accreditation of Hospitals has no right to tell physicians what kind and how much medicine they should give to their patients, and does not do so. The Commission does desire that drugs, especially dangerous drugs, be given properly with reasonable medical staff controls. The Commission is asking that hospital medical staffs establish a written policy that all dangerous medications, not specifically prescribed as to time and number of doses, be automatically stopped after a reasonable time limit set by the staff. It is a protection against indiscriminate, indefinite prescribing of an open-ended type which can result in harm to the patient, physician or hospital. It especially includes such orders as p.r.n., as necessary,' etc. The following classifications are ordinarily thought of as dangerous drugs: narcotics, sedatives, anticoagulants and antibiotics.

EDITOR'S NOTE: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. In previous issues, the following phases of the subject were discussed; August—principles underlying the work of the accreditation commission; September—recommendations of the AMA Stover Committee; October—medical staff meetings; November—medical records; December—responsibilities of the medical staff; January—clinical laboratory services. This is the seventh article in the series.

In subsequent articles as information is available *The Journal* will present suggestions and information from the Joint Commission and answers by the Commission to many varied questions on the activities of the Commission, standards set, hospital administrative problems, etc.

Pharmacy and Therapeutics Committee

This committee is one tool for maintaining medical staff self-government. It is responsible to the medical staff as a whole and its recommendations are subject to medical staff approval. It is not a mandatory committee of the Joint Commission on Accreditation of Hospitals, but is strongly recommended for all hospitals. Composed of physicians and the pharmacist, it serves as the organizational line of communication or liaison between the medical staff and the Pharmacy Department. This

committee assists in the formulation of broad professional policies regarding the evaluation selection, procurement, distribution, use, safety procedures and other matters relating to drugs in hospitals. The purpose and function of this committee are:

a. To serve as an advisory group to the hospital medical staff and the hospital pharmacist on matters pertaining to the choice of drugs.

b. To add to and to delete from the list of drugs accepted for use in the hospital.

c. To prevent unnecessary duplication in the stock of the same basic drug and its preparation.

d. To make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

e. To evaluate clinical data concerning new drugs or preparations requested for use in the hospital.

f. To develop a formulary or drug list of accepted drugs for use in the hospital.

A strong hospital Pharmacy and Therapeutics Committee, meeting at least twice yearly, though not a requirement of the Joint Commission is considered a very important educational and advisory tool towards the improvement of patient care in hospitals and is highly recommended.

Indiana Tightens Its Premarital Physical Examination Law

Ohio physicians, especially those who reside near the Indiana border, should know that the Indiana law relating to premarriage physical examinations has been changed.

Effective January 1, 1958, a three-day waiting period after the application for a marriage license has been filed will be in effect before the license can be issued.

Only a physician holding an unlimited license to practice medicine in Indiana may sign the Physician's Report. However, any licensed physician of another state can submit the applicant's blood specimen to a laboratory approved by the Indiana State Board of Health for the premarital blood test. The laboratory statement and report, returned to the physician on Indiana forms S.B.H. 3-1-10 and 3-1-11, should be given to the applicant who will present them to an Indiana physician for completion of the certificate.

Among acceptable laboratories are state health department laboratories, central or branch, in states outside Indiana and those of the U. S. Armed Forces and U. S. Public Health Service. Reports from private laboratories outside Indiana are not acceptable; reports from approved private laboratories in Indiana, are.

Advice to Woman's Auxiliary On Hotel Reservations for 1958 Annual Meeting

The Woman's Auxiliary to the Ohio State Medical Association will meet in Cincinnati concurrently with the OSMA Annual Meeting. The Auxiliary headquarters and much of the program will be in the Hotel Sheraton-Gibson. Mrs. Charles W. Hoyt and Mrs. Carl F. Schilling, Auxiliary Convention Co-chairmen, have requested ladies to make their hotel reservations early, particularly since Tuesday, April 15, is Opening Day for the baseball season in Cincinnati.

Members of the Auxiliary may use the Hotel Reservation Blank on page 200, this issue for this purpose. Obviously ladies who will accompany their husbands to Cincinnati will want to co-ordinate their reservation to avoid duplicate reservations going from office and home.

American College of Physicians Names Ohio Fellows and Associates

A number of Ohio physicians were honored at the recent meeting of Board of Regents of the American College of Physicians in Philadelphia. The following doctors were named Fellows: Drs. William Stratton Clark, Leonard Frankel, Willem Johan Kolff and Austin Stanley Weisberger, all of Cleveland; and Dr. Oscar Withers Clarke, Gallipolis.

The following Ohio physicians were named as Associates of the College: Dr. Joseph William Kolp, Canton; Drs. William Francis Dowdell, John William Harris, James Stewart Kaufman, Jack Evan Owens and John Gurney Sholl, III, all of Cleveland; Drs. Francis Willard McCoy and Robert Johnson Murphy, Columbus; Dr. Henry Kraus, Cuyahoga Falls; Drs. George Douglas Talbott and Ralph William Tapper, Dayton; Dr. Walter Lloyd George, Euclid; Dr. John Lawrence Bauer, Middletown; Drs. Walter Chilmonczyk and Robert Lewis Schafer, Toledo; Dr. Charlotte Louise Ames, Xenia, and Dr. Herman Harry Ipp, Youngstown.

Dr. Irvine H. Page, Cleveland, was chosen to receive the Ida B. Gould Memorial Award by the American Association for the Advancement of Science at its recent meeting in Indianapolis. He was cited for his research in the field of cardiovascular diseases.

Proceedings of The Council . . .

Budget for 1958 Adopted at Sessions Held December 14-15 in Columbus; Policies are Set on Many Vital Questions; Committees Present Reports

A REGULAR MEETING of The Council of the Ohio State Medical Association was held in the Columbus office on Saturday evening, December 14, and Sunday, December 15, 1957. All members of The Council were present except Dr. C. A. Gustafson, Youngstown, and Dr. William D. Monger, Lancaster. Also present were the following: Mr. Wayne E. Stichter, Toledo, legal counsel; Dr. Jonathan Forman, Columbus, Editor of *The Ohio State Medical Journal;* Dr. Charles L. Hudson, Cleveland, chairman of the Committee on Medical Services, and Past-President of the OSMA; Dr. C. C. Sherburne, Columbus, Past-President of the OSMA, and one of Ohio's AMA delegates; and Messrs. Nelson, Saville, Page, Moore and Edgar.

On motion duly made, seconded and carried, the minutes of meetings of The Council held at Granville, Ohio on September 14 and 15 were approved.

President Martin requested members of The Council to get in touch with their county medical societies and to urge such societies to (1) report their 1958 officers promptly to the Columbus office so that invitations can be sent for the annual conference of county society officers at the Deshler Hilton Hotel, Columbus, on March 2; (2) to consider as soon as possible adoption of the new model constitution and by-laws for county societies, or revision of existing documents to bring them into conformity with the revised OSMA Constitution and By-Laws; (3) to confer with members of the legal profession with respect to the adoption of the statement of principles governing certain physician-lawyer relationships; (4) to advise the county societies to be prepared to instruct their delegates regarding Social Security coverage for physicians after receiving a communication on this from the Columbus office shortly after January 1.

Membership Data

The following data were presented by the Executive Secretary with respect to membership: OSMA membership as of December 12, 1957, 9,052; compared to a total membership of 8,858 on December 31, 1956—an increase of 194 members. Members of the OSMA affiliated with the AMA as of December 12, 1957, 8,018, compared to a total of 7,812 on December 31, 1956—an increase of 206.

Charters To Be Reissued

By official action, The Council approved the issuance of reissued charters to the Gallia County Medical Society and the Portage County Medical Society, each of which had mislaid the charter which had been issued to them.

Amendments Acted Upon

Amendments adopted by the Columbus Academy of Medicine to the constitution and by-laws of that society November 18 were officially approved by The Council.

By official action, The Council approved the new constitutions and by-laws, patterned after the model constitution and by-laws, adopted by the following medical societies: Fulton, Holmes, Lake and Lorain Counties.

Amendments which had been adopted on September 10, 1957, by the Mahoning County Medical Society, and submitted to The Council for action, were referred to the Judicial and Professional Relations Committee and to Mr. Stichter, legal counsel, with instructions that they hold a conference with representatives of the Mahoning County Medical Society on the amendments, some of which are believed to be in conflict with the Constitution and By-Laws of the State Association.

County Society Officers Conference

Reference was made to the Annual Conference of County Society Officers to be held in Columbus, Deshler-Hilton Hotel, Sunday, March 2. The Council decided that there should be a place on the program at that conference for a discussion of the new OSMA policy on third-party medical care plans by Dr. Hudson, chairman of the Committee on Medical Services.

Voluntary Health Organizations

The Council received a voluminous report from the Committee on Relationship Between Medical Societies and Voluntary Health Organizations following more than a year's work. Copies had been supplied members of The Council prior to the meeting. By official action the report was approved and ordered published in *The Journal*; copies to be distributed later to county medical societies.

Budget for 1958

In executive session, The Council acted on recommendations of the Committee on Auditing and Appropriations and officially **approved** the following budget for the calendar year 1958:

The Ohio State Medical Journal	$ 40,000.00
Executive Secretary, Salary	17,500,00
Executive Secretary, Expense	2,000.00
Administrative Assistant, Salary	9,000.00
Administrative Assistant, Expense	1,500.00
Stenographic and Clerical Salaries	36,490.00
President, Expense	1,200.00
President-Elect, Expense	500.00
Council, Expense	4,000.00
AMA Delegates	6,000.00
Dept. of Public Relations ($37,500.00):	
Director, Salary	15,000.00
Director, Expense	2,000.00
Assistant Director, Salary	10,500.00
Assistant Director, Expense	2,000.00
Exhibits and Newspaper Publicity	500.00
Literature	2,000.00
Postage	2,000.00
Supplies	500.00
Miscellaneous Activities	3,000.00
Committees:	
Education	250.00
Judicial and Prof. Relations	400.00
Public Relations and Economics	700.00
Scientific Work	750.00
Auditing and Appropriations	900.00
Chronic Illness	300.00
History and Archives	500.00
Hospital Relations	400.00
Industrial Health	350.00
Maternal Health	1,500.00
Medical Services	500.00
Miscellaneous	500.00
Rural Health	5,000.00
School Health	2,000.00
Annual Meeting	20,000.00
Conference County Society Officers	1,500.00
Emergency and Equipment Fund	4,274.00
Employee Retirement Fund	4,303.00
Insurance and Bonding	3,000.00
Legal Expense	7,000.00
Library	500.00
Postage	2,000.00
Professional Relations Activities	6,500.00
Rent and Utilities	9,075.00
Rural Medical Scholarships	2,000.00
Stationery and Supplies	3,500.00
Telephone and Telegraph	2,500.00
Woman's Auxiliary Contribution	1,500.00
Total	$237,392.00

OSMA Constitution and By-Laws

Mr. Stichter, at the request of The Council, presented a report suggesting certain amendments pertaining to eligibility for membership to the Constitution and By-Laws of the Ohio State Medical Association. By official action, The Council approved the proposed amendment and instructed that it be presented to the House of Delegates at the 1958 Annual Meeting. **(See page 218 this issue of *The Journal.*)**

Mr. Stichter also presented for consideration by The Council suggested amendments providing for an increase in the number of members of the Committee on Scientific Work and changes in some respects in the activities of that committee, which were officially approved by The Council and ordered submitted to the House of Delegates at the 1958 Annual Meeting. **(See page 218 this issue of *The Journal.*)**

United Mine Workers Welfare and Retirement Fund

A resolution from the Belmont County Medical Society and a resolution from the Tuscarawas County Medical Society pertaining to the new policies and regulations of the United Mine Workers Welfare and Retirement Fund were brought up for consideration. Communications from several other county medical societies endorsing the Belmont County resolution were read. The resolutions read as follows:

Belmont County Resolution

Whereas, We firmly believe in the principle of the free choice of physician and hospital to be one of the inherent rights and liberties of any American citizen.

1. We, the physicians of the Belmont County Medical Society, recommend that the Council of the Ohio State Medical Association take the proper action to declare that within the Ohio State Medical Association, any physician of the State of Ohio, who knowingly or willingly participates in, or aids and abets the operation of, a medical plan which denies or limits its beneficiaries the right of free choice of physician or hospital, except as specified by law, shall, upon conviction thereof by the medical tribunal specified in the constitution of the Ohio State Medical Association, be found guilty of unethical conduct and subject to discipline by the Ohio State Medical Association.

2. We direct the secretary of this society to send a copy of this recommendation to the Council of the Ohio State Medical Society along with the urgent request that the Council consider this problem and bring it before the House of Delegates of the Ohio State Medical Society, in special session, for statewide action.

3. We direct the secretary of this society to see that copies of this action be transmitted to the secretary of each society.

Tuscarawas County Resolution

Whereas, there is a situation within Tuscarawas County which directly interferes with the fundamental right of an individual to make his own free choice of a

physician, be it therefore resolved, that the following be spread upon the minutes of the Tuscarawas County Medical Society:

It is the belief of the Tuscarawas County Medical Society that the code of ethics of the American Medical Association forbids any of our members to engage in any medical or surgical practice where there is interference with the free choice of physicians and where a third party dictates the physicians to be employed and thereby acts as the third party between physician and patient.

Furthermore, it is the belief of this Tuscarawas County Medical Society that all of its members who are now so engaged should immediately resign as panel physicians for any organization which follows the pattern as set above.

Study By Committee

President Martin advised The Council that these resolutions and the entire UMW matter had been thoroughly considered by the Committee on Medical Services at a meeting on November 17, 1957. He asked The Council to consider at this time the special report prepared by that committee.

The committee's report was presented and discussed in detail by Dr. Hudson, chairman of the committee, and by Mr. Stichter, legal counsel, and Executive Secretary Nelson, both of whom had assisted the committee in the preparation of the report. Dr. Hudson also reported to The Council that the committee recommends that an educational program be carried on in all parts of the state to acquaint the public generally with the reasons for the various ethical pronouncements set forth in the report in order to show the public that these matters are fundamental in preventing deterioration in the quality of medical care. By official action, The Council approved this idea and instructed the committee to present a detailed plan of education for consideration at an early meeting of The Council.

Statement Adopted

The special statement of policy on this question was officially approved by The Council, which instructed the Executive Secretary to see that the statement is published in full in the January issue of *The Journal;* that copies are sent to the president and secretary of each county medical society in the state; and that a copy is sent to each member of the OSMA in the Seventh Councilor District. **(See pages 86-91 January issue of *The Journal* for text of report.)**

Medicare

At this point Dr. Hudson reported on a conference on medicare which he attended on behalf of the OSMA at Philadelphia on December 6, 1957, the day following the AMA clinical session. By official action, The Council authorized Dr. Hudson to attend a meeting January 11-12 in Atlanta, Ga., at which various states interested in promoting medicare as an idemnity program will be asked to send representatives.

Fluoridation of Water Supplies

The Council, by official action, adopted the following new statement of policy on the question of fluoridation of public water supplies:

The Council of the Ohio State Medical Association endorses the conclusions of a report on fluoridation issued jointly by the Council on Drugs and the Council on Foods and Nutrition of the American Medical Association and approved by the AMA House of Delegates in session on December 5, 1957, at Philadelphia.

The conclusions of the approved report are as follows:

1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1 ppm of fluorine in drinking water has been established as a method for reducing dental caries in children up to 10 years of age. In localities with warm climates, or where for other reasons the ingestion of water or other sources of considerable fluoride content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least 44 years of age.
2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1 ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries - inhibiting effect of the fluoride.
3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of 1 ppm of fluorine.

The Council of the Ohio State Medical Association is of the opinion that projects involving fluoridation of public water supplies should have the prior approval of the county medical society and the local dental society serving the area, as well as the appropriate agencies of local government.

Report on 1958 Annual Meeting

The Executive Secretary reported on progress being made in program arrangements for the Annual Meeting. He passed out to each member of The Council a detailed breakdown on the day-by-day schedule of events.

Research Fund

The Council reviewed a letter from Dr. R. E. Tschantz, Canton, suggesting that the OSMA sponsor a study of the amounts raised by single health agencies; evaluate cost of raising the funds; and consider the possibilities of the establishment of a single Ohio Medical Research Fund. The Council referred this matter to the Committee on

Relationship Between Medical Societies and Voluntary Health Organizations for study and action.

Report from TB Society

A letter from the Ohio Tuberculosis and Health Association was read and filed. It stated that the Board of Directors of that association on December 5 adopted a report of a special committee named to study a resolution on federated fund-raising adopted by the OSMA House of Delegates in May, 1957, which report listed arguments in favor of independent fund-raising campaign and arguments against a federated fund program. The report which was approved by the tuberculosis society board read as follows:

Text of Report

"The Special Committee of the Ohio Tuberculosis and Health Association, appointed to study the implications of a Resolution passed by the House of Delegates of the Ohio State Medical Association in May, 1957, met on September 11 to fulfill its charge.

"The Resolution under study 'approves the principle of a federation at the local level of all voluntary health agencies and the raising of funds for the federation through a single fund-raising campaign.'

"The Special Committee recommends that its report, as follows, be adopted by the Board of Directors of the Ohio Tuberculosis and Health Association as a statement of policy; that copies be distributed to county associations for their guidance; and that a copy be sent to the Ohio State Medical Association.

"1. A federated fund-raising campaign for all health agencies is contrary to the basic freedom of philanthropy and might lead to bureaucratic control. The right to choose the agencies one wishes to support and the amount one wishes to give is a cherished freedom, comprising the fundamental difference between voluntary giving and compulsory giving which is tantamount to taxation.

"2. A federated fund-raising campaign for all health agencies would undermine the quality of individual agency programs by destroying a healthful competition for public support and would encourage the existence of groups which are unable to earn such support based on their own program performance.

"3. A federated fund-raising campaign for all health agencies would result in loss of community interest in, and action on, specific health problems. Voluntary health agencies would tend to lose their identity and hence their individual appeal. Dissipation of public interest would result in serious damage to their programs.

"4. A federated fund-raising campaign for all health agencies is contrary to the policies of the local, state, and national tuberculosis associations adopted after years of successful experience in independent fund-raising.

"5. The Christmas Seal Sale provides educational and promotional support for tuberculosis control programs as well as a dependable method of fund raising. (See attached principles.)

6. The tuberculosis program has had capable professional advice and consultation through its medical sections, the American Trudeau Society, and the Ohio Trudeau Society, and through active participation of physicians on the boards of national, state and local associations. This close and valuable liaison has been in accordance with established principles of the medical profession."

Research Conference in Chicago

A communication from the Council on Medical Service of the AMA was received requesting the Ohio State Medical Association to send representatives to a meeting in Chicago on January 19, to discuss the Ohio resolution on a united research fund which was presented at the June, 1957, session of the AMA and referred to the special committee of the Council on Medical Services of the AMA for consideration. By official action, The Council instructed the Executive Secretary to request Dr. R. E. Tschantz, Canton, who presented the original resolution in the OSMA House of Delegates, and Dr. T. L. Light, Dayton, a member of the OSMA committee on this subject, to attend the January 19 meeting, if possible.

Complaint on UMW Claim

A report on other actions taken by the Committee on Medical Services on November 17 was submitted by the Executive Secretary, as follows, and approved by The Council:

Correspondence between a Cleveland physician and Dr. Falk of the UMW area office was considered. This involved refusal on the part of the UMW to pay all of the physician's bill for services to a UMW beneficiary.

The committee felt that inasmuch as the physician had requested the Cleveland Academy of Medicine to consider this matter and to render an opinion, that the correspondence should be returned to the Academy of Medicine of Cleveland with a recommendation that the Academy take up the question with Dr. Falk in an effort to work out a satisfactory settlement. The Executive Secretary was instructed to advise the Cleveland Academy of Medicine of this opinion by the committee and to offer the services of this committee, in event the Academy is unable to work out a satisfactory agreement.

Medicare Matters

The committee requested Dr. Hudson to attend a conference on "Medicare" sponsored by the AMA on the day following the AMA meeting in Philadelphia, namely, Friday, December 6, and Dr. Hudson consented to attend the meeting representing the Ohio State Medical Association. The committee suggested to Dr. Hudson that he should advise the Philadelphia conference, if the opportunity presented itself, that the Ohio State Medical Association still favors making "Medicare" an indemnity program and that it would be easy to convert the "Medicare" program into an indemnity program simply by eliminating the administrative ruling that Government allowances must be considered as "payment-in-full" and that a new ruling could be issued which would permit the physician, in certain cases, to charge the patient the difference between the Government's al-

lowances and the bill for services rendered. Also the committee expressed the opinion that the representatives of the AMA on the Medicare Advisory Committee should be more emphatic in supporting the action taken by the AMA House of Delegates on this question at the June, 1957 AMA meeting.

Veterans Administration Schedule

A request from the Veterans Administration that a new format be developed for the medical fee schedule applying to the home-town VA program in Ohio, was considered. The committee felt that it was not in a position at present to take any action. It instructed the Columbus Office staff to prepare material on the existing fee schedule and possible changes in certain items for consideration by the committee at its next meeting.

Division of Aid for Aged

A letter from a physician expressing dissatisfaction with a decision made by Dr. Charles R. Wilcox, Medical Director of the Division of Aid for the Aged, on a bill for medical services, was discussed. It was the belief of the committee that additional information would be necessary before a decision could be made by the committee. This was held for action at the next committee meeting.

Copies of several letters from Cleveland physicians to the Executive Secretary of the Cleveland Academy of Medicine, expressing dissatisfaction with rulings made by the Division of Aid for the Aged, were discussed.

Consideration also was given to a letter from the Columbus Academy of Medicine recommending certain changes in administrative details involving the Aid for the Aged program.

The committee felt that it would be advisable and necessary to hold a conference with officials of the Division of Aid for the Aged, on these and other policy matters. The Executive Secretary was requested to set up a tentative date for such a meeting shortly after the first of the year.

Fees Paid Internists

Consideration was given to a letter from Dr. Arnoldus Goudsmit, President of the Ohio Society of Internal Medicine. In his letter Dr. Goudsmit pointed out that the internists believe that the amount of $15.00, which is now paid by the Bureau of Vocational Rehabilitation for examinations by internists in "disability freeze" cases is inadequate. The letter indicated that a fee closer to the "Medicare" fee of $50.00 would be more equitable. It requested the Ohio State Medical Association to take action on this request. The committee requested the Executive Secretary to discuss this subject with officials of the Bureau of Vocational Rehabilitation and to submit a report at the next meeting of the committee.

Committee on Public Relations

Actions taken by the Committee on Public Relations and Economics at a meeting October 6 were reported to The Council by Mr. Saville, and approved by The Council.

The report stated that progress is being made on the question of setting up standards for clinical laboratories and on the matter of trying to simplify and standardize forms used by insurance companies. These will be considered again by the committee at its next meeting, the report pointed out.

Definite action was taken on October 6 by the committee, and approved by The Council, on the following:

Diabetes Detection Program

The committee heard a report by Dr. Frederick H. Wentworth, Ohio Department of Health, on the diabetes case-finding program sponsored by the Ohio Department of Health, the Union County Medical Society, and other community agencies in that county. He stated that 2757 persons had received blood sugar tests. Of these, 155 were suspects requiring a follow-up. Of this number, 97 required glucose tolerance tests. Of 28 persons sent to physicians, 23 were diagnosed as having diabetes. Dr. Wentworth stated that the cost of the program was approximately $1 per screenee, or an average of $98 to find each positive case. It was his opinion that the program had been well accepted by the community and the medical profession and that it had been generally beneficial to the community. The committee also studied a report on the Union County Blood Sugar Screening Project presented by Robert A. Vogel, M. D., Health Commissioner, Union County, at the September 18-20, 1957 annual Conference of Health Commissioners. After careful consideration of the ramifications of the program and particularly the cost involved, the committee by unanimous vote reaffirmed the policy adopted by the committee on this question November 3-4, 1956, and approved by The Council, December 14, 1956, reading as follows:

> "The desirability of early recognition of disease in general is recognized. However, the philosophic concept of governmental case-finding of a non-communicable, non-industrial, naturally-occurring disease, the cost per case of those found, and the chances of favorably influencing the ultimate outcome of the dis-

ease are questionable to the extent that the committee does not approve of the project."

Rheumatic Fever Program

The committee considered the program of the Ohio Department of Health for making available to practicing physicians on request, through their local health departments, antibiotics for the prevention of recurring attacks of rheumatic fever. The Council referred this matter to the committee at its meeting on April 27, 1957. Dr. Wentworth explained this program, an article covering which appeared in the April, 1957 issue of *The Ohio State Medical Journal,* pages 474-5. He pointed out that local health departments had been advised by the Ohio Department of Health to confer with local medical societies in working out details for administering the program.

The committee could see no objection to the program because the use of the antibiotics furnished by the health department is solely at the discretion of the attending physician.

Corporate Practice

Dr. Orr, chairman of the Committee on Hospital Relations, and the Executive Secretary reported on three joint meetings which have been held by the hospital relations committee and the Judicial and Professional Relations Committee. The principal question considered at those meetings was the legal and ethical aspects of corporate practice of medicine. The reports stated that additional meetings during the Spring of 1958 are being planned and that the committees are not prepared as yet to report either to The Council or the House of Delegates. This progress report from the two committees was approved by The Council.

House of Delegates Procedures

Mr. Saville reported for the Special Committee on House of Delegates procedure which was created as a result of a resolution adopted at the 1957 Annual Meeting by the House of Delegates. The committee's report was approved by The Council. Main provisions of the report appear on page 213 this issue of *The Journal.*

Cancer Committee

The Council heard and approved a report from the Executive Secretary on a meeting of the Cancer Committee and the Cancer Coordinating Committee on November 3. Highlights of the report appear on page 216 this issue of *The Journal.*

Workmen's Compensation

Mr. Saville reported for the Committee on Industrial Health and Workmen's Compensation, in behalf of the chairman, Dr. H. P. Worstell. He stated that the upward revisions in certain items in the Workmen's Compensation fee schedule recommended by the Committee had been presented to Mr. James L. Young, the BWC Administrator, and are now receiving his consideration.

It was reported that the Commission's new mechanized method for payment of doctor's bills is now in effect, and that the new system would result in prompt payment of these bills.

Included in the committee's report, which was approved by The Council, was a recommendation that the BWC be requested to revise its contract with hospitals to permit hospitals to include the cost of anesthetic supplies in their per diem costs and to eliminate the provision in the fee schedule that the Bureau expects the anesthetist to supply anesthetic material without compensation beyond the professional fee allowed in the schedule. An agreement on this question was reached in a conference between representatives of the Committee and representatives of the Ohio Hospital Association and the Ohio Society of Anesthesiologists, and approved by these organizations. The proposition will be presented to officials of the BWC at an early date.

Industrial Health

The Council also approved a recommendation of the committee that its activities be enlarged, and that the work of the committee be divided, with one subcommittee handling matters relating to Workmen's Compensation and a second subcommittee handling matters relating to industrial health, industrial hygiene and industrial health programs generally. President Martin was instructed to enlarge the personnel of the committee accordingly.

Report on AMA Meeting

Doctors Woodhouse, Sherburne and Hudson presented a detailed report on the actions at the AMA House of Delegates at the recent Philadelphia meeting. **(See pages 81-83 January issue of *The Journal* for detailed story.)**

Forand Bill

By official action, The Council adopted a statement of policy with respect to the so-called Forand Bill, H. R. 9467, which will be considered at the next session of Congress starting in January. **(See page 85 of January issue of *The Journal.*)**

The Executive Secretary was instructed to send a copy of this statement to all Ohio Congressmen and to the legislative chairmen of all county medical societies, requesting that they also discuss this

bill with their respective members of Congress and urge them to vote against it should it come to a vote.

Report on Research Animal Procurement

Mr. Edgar presented a report on what is being done in Ohio under the provisions of HB 384, the law passed at the 1957 session of the Ohio General Assembly to provide more dogs for medical research. His report was as follows:

There have been 16 institutions certified by the Ohio Public Health Council as eligible for participation under the provisions of HB 384. At Ohio State University, it was reported that steps are being completed to have everything in order for procurement, and that pound officials have assured cooperation. The University of Cincinnati program already is in operation and working smoothly. Cleveland institutions were reported prepared to begin requisitioning in the near future. The Ohio Public Health Council has 13 additional applications for certification to consider at its next meeting.

Ethics of Group Practice

Action which was taken at the December, 1957, AMA meeting on ethical aspects of group practice was discussed and endorsed, such action reading as follows:

Whereas, It has been found by experience that physicians practicing as a partnership, association or as members of other lawful group arrangements can preserve the physician-patient relationship, insuring that medical responsibility lies in the hands of the patient's own doctor and not in the hands of an unlicensed person or entity; and

Whereas, The ethical principles of the AMA apply to the individual physician whether he practices alone or with a group; So therefore be it

Resolved, That the House of Delegates affirm that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other lawful groups provided that the ownership and management of the affairs thereof remains in the hands of licensed physicians.

AMEF Program

Reporting for Dr. Merrill D. Prugh, Ohio Chairman for the American Medical Education Foundation, Mr. Saville stated that as of November 30, 1957, Ohio contributors to AMEF numbered 529, for a total of $24,652.94. Comparable figures for 11 months in 1956 were 430 and $21,303.25.

OMI Nominating Committee

The Council authorized President Martin to appoint a nominating committee to present nominees for the Board of Directors of Ohio Medical Indemnity for the annual stockholders meeting of OMI next April, the nominating committee report to be acted upon at the March 1 meeting of The Council.

Mahoning County Report

A report of the Committee on Industrial Health of the Mahoning County Medical Society with respect to diagnostic programs for employes of industry was considered and copies passed out to members of The Council pursuant to a request which had been made by Dr. Gustafson by letter.

President Martin advised members of The Council that Dr. Monger has been seriously ill but is now convalescing satisfactorily. The Council adopted a resolution wishing him a speedy recovery.

The Council then adjourned to meet on Saturday, March 1.

Attest: CHARLES S. NELSON,
Executive Secretary.

General Physicians Sponsor Cincinnati Symposium on Neurological Problems

Symposium on Selected Medical and Neurological Problems is the title of the Lederle Symposium to be presented at the Netherland-Hilton Hotel, Cincinnati, Sunday, February 23. Sponsored by the Ohio Academy of General Practice in collaboration with the Southwestern Ohio Society of General Physicians, registration will be held from 9:00 to 10:00 a. m.

The morning program consists of papers by Dr. Edward Litin, Mayo Clinic, entitled "Emotional Development of Children"; "The Differential Diagnosis and Treatment of Borderline Thyroid," by Dr. G. H. Marquardt, Chicago; and "The Recognition of Allergic Reactions During Drug Therapy," by Dr. Samuel M. Feinberg, Chicago.

The afternoon scientific session consists of the discussions on "The Significance and Accuracy of Laboratory Reports," by Dr. Louis S. Smith, Dallas, Texas; "Indications For the Use of Hormones and Tranquilizing Agents in the Treatment of the Menopause and Nervous Tension States," by Dr. William E. Barfield, Augusta, Ga., and "Intracranial Bleeding," by Dr. Frank H. Mayfield, Cincinnati.

Dr. Morton Hamberger, of Cincinnati, will be the moderator for the morning session. Dr. Richard Vilter, Cincinnati, and Dr. Robert L. McLaurin, Cincinnati, will be moderators for the afternoon program.

The physicians are urged to bring their wives for the day and a program has been planned for them.

Emotional Disorders Under Medicare . . .

Only in Exceptional and Unusual Cases Is the Treatment of Emotional Disorders Under the Program for Dependents' Medical Care Authorized

TREATMENT of nervous and mental disorders under the Dependents' Medical Care program is authorized only in special and unusual cases, according to a communication from the Medicare office in Washington. Following is the text of ODMC Letter No. 2, dated January 2, 1958, and signed by Maj. Gen. Paul I. Robinson, executive director of the Office for Dependents' Medical Care:

Acute Emotional Disorders

1. This letter supersedes ODMC Letter No. 8, dated 20 March 1957.

2. Treatment of nervous and mental disorders is not authorized under the provisions of the Dependents' Medical Care Act, Public Law 569, 84th Congress, except in special and unusual cases (see Sec. 103(g)(2) and Sec. 204).

3. The authority given the Secretary of Defense to make exceptions for hospitalization of patients for nervous and mental disorders in uniformed services medical facilities requires some explanation from a practical view. The delegation of this authority is further made to the Surgeon General of the respective service by paragraph 404 b of the Joint Directive for Implementation of the Dependents' Medical Care Act (P. L. 569, 84th Congress), dated 18 October 1956. The Surgeon General of the respective uniformed service is also authorized to transfer eligible dependents from civilian facilities to uniformed services medical facilities for treatment of acute emotional disorders by paragraph 502 g, Joint Directive for Implementation of the Dependents' Medical Care Act. However, beds available for women and children in uniformed services medical facilities for the treatment of nervous and mental disorders are few in number. In general, they are sufficient only for female uniformed service members and for dependents having nervous and mental disorders who are evacuated from outside continental United States. Therefore, transfer from civilian facilities to uniformed services facilities in the continental United States will rarely be accomplished.

4. Paragraph 502 g of the Joint Directive recognizes the need for authority to hospitalize in civilian facilities cases of acute emergency, including acute emotional disorders. The mentioned paragraph states in essence that hospitalization and medical care are authorized at Government expense for such emergencies only pending completion of arrangements for care elsewhere unless the illness or condition also qualifies for hospitalization under other provisions of the Law or Directive. This is interpreted to mean that the Government is liable for payment of the hospital and physicians' bills only:

a. Until the acute emotional disturbance subsides; or

b. Until the sponsor can arrange for care at other than Government expense, whichever is earlier.

The judgment and integrity of the attending physician must be relied upon to determine when the acute emotional disturbance subsides and his word will be unquestioned except when there is evidence to the contrary. Likewise, the judgment of the physician must be relied upon to determine the probable duration of hospitalization which will be required for each individual patient.

5. In order to establish a working arrangement so that fiscal administrators will be able to handle many cases without referral to the Office for Dependents' Medical Care, bills may be paid without further reference:

a. If the physician states the condition was one of acute emotional disorder constituting an emergency requiring hospitalization for the life, health or well-being of the patient, regardless of psychiatric diagnosis; and

b. If the duration of hospitalization for the acute emotional disorder **did not exceed 21 days.**

When the Government's liability terminates not later than 21 days, the DA Form 1863 for the physician and hospital should show the type of disposition which has been made. This will aid contractors in making prompt payments.

6. Extension of medical care beyond 21 days at Government expense may be granted only by the Contracting Officer, Office for Dependents' Medical Care, and the basis for such extension is as follows:

a. Extensions beyond 21 days may be considered for short periods of time for the following reasons:

(1) When there is necessity for more time for the sponsor to assume responsibility. Examples: (a) sponsor's return from overseas

station, sea duty, etc.; (b) difficulty in obtaining agreement of state or municipal institution to accept patient;

(2) When retention in the hospital for a matter of two or three weeks will result in a cure or remission which will permit patient to return home;

(3) When underlying diagnosis for determination of length of care cannot be made within the 21-day period.

b. The procedure for requesting an extension of hospitalization beyond 21 days is as follows:

(1) Upon admission of a patient under the Dependents' Medical Care Program, the hospital administrator should immediately contact the charge physician to ascertain the length of time hospitalization will be required for the acute emergency;

(2) If the attending physician is of the opinion that hospitalization will be required beyond a 21-day period, the hospital administrator should immediately obtain from the attending physician a report containing information specified in subparagraph (3) below and forward *direct* to the Contracting Officer, Office for Dependents' Medical Care, Office of The Surgeon General, Washington 25, D. C. A copy of this report will be sent to the contractor paying the hospital and the physicians. Because of the shortness of time, this report must be submitted by the end of the first seven days of hospitalization and be forwarded by air mail, if more expeditious;

(3) The report will be clinical in nature and will show the name of the dependent, date of admission, diagnosis, nature of acute emergency, prognosis, service member's name, serial number, branch of service, the physician's name, and the length of time for which extension of hospitalization at government expense is requested with appropriate reasons therefor.

7. In those cases when extensions of time beyond 21 days are granted by the Contracting Officer, the DA Forms 1863 submitted by the hospital and physician must have attached thereto a copy of the Contracting Officer's authorization.

8. Procrastination and delay on the part of an available sponsor to arrange for care of the patient at other than government expense will in no case be considered reason for extension of the 21-day period.

9. On receipt of request for extension of medical care beyond 21 days, the Contracting Officer will determine if facilities are available for further care in uniformed services facilities, and if so, will notify the hospital and contractors. If an extension of time is not justified or uniformed services facilities are not available, the Contracting Officer will notify the hospital and contractors of the date when the Government's liability for payment did or will terminate.

10. Physicians accepting patients with acute emotional disorders under the Dependents' Medical Care Program have the great responsibility of making recommendations which are compatible with the Law governing the Program. They must determine that the acute emotional disorder is one which constitutes an acute emergency and that hospitalization is necessary for the life, health or well-being of the patient. They should institute treatment as indicated and at the same time begin discussions with the sponsor which will lead to the proper treatment and care of the patient at other than Government expense.

11. Outpatient care prior to or after hospitalization as an inpatient is not authorized for acute emotional disorders. Treatments so rendered (electro-shock treatment, occupational therapy, etc.) are the responsibility of the patient.

12. The attending physician may not charge for examinations or treatments when, in fact, they were performed by interns, residents, or other ancillary medical personnel.

* * *

Admissions for Diagnostic Surveys Under Medicare Clarified

Following is a communication from Maj. Gen. Paul I. Robinson, executive director of the Office for Dependents' Medical Care:

1. Based upon inquiries received, it appears that some misunderstanding exists as to the extent that admissions for diagnostic purposes are authorized under the Dependents' Medical Care Program. The following is a restatement covering the scope of such admissions as may be authorized for coverage under the program.

2. Diagnostic admissions, *per se,* are not authorized under the Dependents' Medical Care Program in civilian facilities. Once a patient is admitted to a hospital for an "acute medical or surgical condition," payment for diagnostic tests and procedures, including laboratory tests and pathology and x-ray examinations, when ordered by the attending physician, are authorized. This is interpreted to include those cases evidencing manifestations of an acute illness requiring hospitalization for proper treatment even though a firm diagnosis had not at the time of admission been determined. When it is determined that the acute illness requiring hospitalization is an acute exacerbation, or a complication of a chronic disease, or other condition not covered under Public Law 569, the liability of the Government is limited to treatment of the acute phase only.

House of Delegates Procedure . . .

Special Committee Assigned To Study This Question Makes Report To The Council at December Meeting; Handbook for Delegates Authorized

AT the December meeting of The Council, a detailed report was presented by a special committee which has been studying ways of improving the transaction of business by the House of Delegates of the Ohio State Medical Association—a request made in a resolution adopted at the 1957 Annual Meeting.

Members of the committee are: Dr. Charles W. Hoyt, Cincinnati, chairman; Dr. Paul J. Schildt, Lakewood; Dr. Donald W. English, Lima; Dr. Robert M. Inglis, Columbus; and Dr. Harlin G. Knierim, Mansfield. All have been long-time members of the House of Delegates. Mr. Saville, assistant executive secretary, served as secretary of the committee. The committee was assisted in its work by Dr. George A. Woodhouse, President-Elect of the Association, and a long-time member of the House of Delegates of the AMA.

Commended for Innovations in 1957

In its report to The Council, the committee expressed the opinion that officials of the Ohio State Medical Association should be commended for improvements initiated at the 1957 session in Columbus. These innovations included the appointment of two reference committees on resolutions so that more time was available for consideration of the various resolutions presented; making available mimeographed copies of the resolutions the day following the opening session; and also providing the delegates with mimeographed copies of the reference committees' reports at the closing session. The committee also approved the present system of registering in delegates and alternates in lieu of having a roll call.

It recommended that the plan of having the first session of the House of Delegates a dinner meeting on Monday evening with the final session a Thursday morning breakfast be continued. It was pointed out that this gave adequate time for consideration of resolutions by the reference committees.

Deadline on Resolutions Suggested

The committee considered ways and means of getting copies of resolutions to the delegates in ample time before the meeting so that the resolutions could have the careful consideration of the delegates and so that they could determine the reaction of the members of their county societies to the resolutions. It voted to recommend to The Council that the House of Delegates at the 1958 annual meeting be requested to amend the By-Laws of the Ohio State Medical Association as follows:

> "All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than sixty days prior to the meeting of the House of Delegates to which the resolutions will be presented for action:
>
> Provided, that this sub-section of the By-Laws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates."

What Would Be Accomplished

Members of the committee felt that the adoption of this amendment to the By-Laws would accomplish the following: (1) Copies of resolutions could be sent to the delegates for study well ahead of the time of the meeting; (2) Copies of resolutions could be published in the first available issue of *The Ohio State Medical Journal* prior to the meeting; (3) By having the resolutions early, the delegates could present them at a meeting of the county medical societies prior to the annual meeting of the Ohio State Medical Association and obtain the reactions of the county societies to the context of the resolutions.

Recommend Handbook

The committee also recommended to The Council:

1. That the State Headquarters staff produce a handbook on procedure in the House of Delegates, this handbook to be sent to all delegates prior to the annual meeting. In addition to the order of business, rules, and general mechanism of the House of Delegates, the committee suggested that special attention be called in the handbook to the desirability of careful drafting of resolutions so that mis-statements and inflammatory statements are avoided.

2. It was felt that the introduction of resolutions should be stimulated, but that attention should be called to the public relations' implications of carelessly-worded resolutions.

3. Stenographic service should be supplied to each reference committee on resolutions so that accurate notes can be made during the committee

hearings, and actions of the committee accurately recorded.

4. Through *The Journal* and *OSMAgram,* it should be publicized that all members of the Association may attend meetings of the reference committees.

5. A definite listing of the time and place of meetings of the reference committees and time schedules of hearings on the various resolutions should, if possible, be announced and posted at the time of the first session of the House of Delegates.

Influenza Causes Slight Increase In Mortality for the Year

Reflecting largely the widespread outbreak of Asian influenza, the general mortality in the United States increased moderately in 1957, according to the statisticians of the Metropolitan Life Insurance Company.

The national death rate for 1957 is estimated to be 9.6 per 1,000 population, compared with 9.4 for 1956. It is the tenth year in succession to record a rate below 10 per 1,000.

Since the beginning of September, the acute upper respiratory diseases, including Asian influenza, have disabled about half the population for at least one day, according to information available from the current National Health Survey. Although the case fatality rate for the respiratory diseases has been relatively low, the death rate from influenza and pneumonia as a group increased in 1957, rising to about 34 per 100,000. This is the highest rate in about a decade, but less than half that recorded in any year prior to 1941.

In sharp contrast to the influenza pandemic of 1918-19, the excess mortality resulting from the recent outbreak was concentrated in large measure among people past age 55. A considerable part of the rise in general mortality occurred among people who had disorders of the heart and arteries.

One of the outstanding features of the year's health record is the marked reduction in cases of poliomyelitis. "About 6,000 cases of the disease were reported in the United States during 1957. This compares with more than 15,000 cases reported in 1956, about 29,000 in 1955, and with nearly 58,000 in 1952.

The continued decline in mortality from tuberculosis is another favorable aspect of the health record. Infant and maternal mortality in 1957 continued at the all-time low levels established the year before.

Dr. Sollmann Honored as "Dean of American Pharmacology"

Dr. Torald Sollmann, 83, Dean Emeritus of Western Reserve University's School of Medicine in Cleveland, Ohio, received the Annual Award of the American Pharmaceutical Manufacturers' Association (APMA) at a dinner in the Waldorf-Astoria, New York, on December 10.

Honored as the "Dean of American Pharmacology," Dr. Sollmann came to national prominence in 1917 when he published the first textbook on pharmacology in the English language. The book in revised form is still a standard text for medical students.



Dr. Sollmann

Francis Brown, president of APMA, cited Dr. Sollmann's work on the Council on Pharmacy and Chemistry of the American Medical Association. He is a charter and still active member of the Council, and has served as chairman for more than 20 years.

Dr. Sollmann has also contributed "unselfishly of his wisdom to the nation's military services, the Department of Agriculture, and other federal, state and local government agencies," said Mr. Brown, who is also president of the Schering Corporation.

Dr. Sollmann was born in Coburg, Germany, in 1874. He became a naturalized U. S. citizen in 1896 and received his M. D. degree from Western Reserve University the same year. Other degrees include an L. L. D. from Western Reserve University, and an Hon. D. Sc. from Ohio State University.

He has also servved as a consultant to the U. S. Public Health Service since 1935; a member of the Executive Revision Committee, U. S. Pharmacopoeia from 1910 to 1930; consultant, U. S. Army, U. S. Navy and U. S. Department of Agriculture, 1902, 1917. He is a Fellow, American Medical Association and member of many professional organizations.

Cincinnati Area GP's

Heart Disease was the theme at the January 19 program of the Southwestern Ohio Society of General Physicians at the Hartwell Country Club. Joint sponsors were the Heart Association of Greater Cincinnati and the University of Cincinnati College of Medicine.

Next meeting will feature the Lederle Symposium entitled, "ENT and Allergic Disorders."

Social Security for Doctors . . .

Each County Medical Society in Ohio Has Been Sent Letter Urging The Society To Instruct Its Delegate or Delegates on This Question

ON January 14, Dr. Robert S. Martin, president of the Ohio State Medical Association wrote to the President of each County Medical Society in Ohio as follows:

"Dear Doctor:

"The Council of the Ohio State Medical Association has requested me to strongly recommend that each County Medical Society instruct its delegate (or delegates) how to vote on the following question which may be introduced at the 1958 Annual Meeting in Cincinnati, April 15-17:

"Should, or should not, the Old Age and Survivors Insurance section of the Federal Social Security Act be amended to extend coverage to all doctors?

"The Council believes each County Medical Society should poll its members on this subject so delegates will have the sense of the membership. It suggests each society be prepared to furnish statistics on the number voting and the results.

"How to give your members the pros and cons is a matter to be determined by you. If you desire to send data on this subject to your members, and you believe the enclosure would be satisfactory, let the Columbus Office know how many copies you will need and we will send a supply to you.

"The Council believes that this method of having each County Society determine the views of its membership on this question is more practical than a state-wide referendum such as the one conducted by the State Association in the Fall of 1955. At the time of the 1955 poll, ballots were sent to 8,360 members; 4,912 ballots were returned; 2459 ballots were cast in favor of Social Security coverage (370 for compulsory, 2070 for voluntary and 19 with no preference stated) and 2441 ballots were cast against coverage, either voluntary or compulsory. Twelve ballots could not be counted because of irregularity in markings.

"I urge your society to give this question consideration as promptly as possible so your delegate (or delegates) will know the will of your membership if he is called upon to vote on this issue at this year's Annual Meeting."

It is assumed that each County Medical Society is giving thought to this question; will advise its delegate (delegates) how the members feel about this subject.

The "pro" and "con" statement which accompanied Dr. Martin's letter was set in type and multiple copies offered to county societies wishing to send a copy to members.

Bunts Institute of Cleveland Offers Course for General Practitioners

The Frank E. Bunts Educational Institute affiliated with The Cleveland Clinic Foundation is offering the fifth annual day and one-half postgraduate course of particular interest to general practitioners. This course, open to all members of the medical profession, is sponsored by the Cleveland Chapter of the American Academy of General Practice and has been approved for 10 hours' credit.

The course will be held on the fourth floor of the North Clinic Building, located at Euclid Avenue and East 93rd Street.

The following topics are scheduled on Wednesday, February 12:

Obstetrics and Gynecology—Gynecologic Problems During Pregnancy; Gynecologic Problems after Pregnancy; Office Diagnostic Procedures in Gynecology.

Pediatrics—The Handicapped Child; The Uncommon Types of Epilepsy in Children; Evaluating Intelligence in Children.

Therapy—Stapes Mobilization; Symbiotic Combinations in Antibiotic Therapy; Practical Approach to Problems of Electrolyte Balance.

Trauma—The Orderly Approach to the Injured Patient; Management of Ocular Injuries; Immediate Management of Chest Injuries.

The following topics are scheduled on Thursday, February 13:

Old Timers Session — Psychoneurotic States; Common Geriatric Dermatoses; Functional Mechanism of Pain; Changing Concepts of Renal Disease.

Miscellaneous Topics—Cine-Cardioangiography in the Diagnosis of Congenital Heart Disease; Obesity and Longevity; Dermatologic Lesions of the Anal Area; Common Diagnoses in Office Proctology.

Thursday afternoon tour of Hospital and Clinic.

Cancer Registry Activities . . .

Report Made at Recent Committee Meeting Is Presented to The Council: Problems Aired; Plans for Future Acted Upon; Ask for Legal Opinion

A REPORT on the status of cancer reporting in Ohio and progress being made by the Ohio Cancer Registry was presented to The Council of the Ohio State Medical Association in December by the Cancer Committee and the Cancer Coordinating Committee.

Members of the Cancer Committee are: Drs. Arthur G. James, Columbus, chairman; C. E. Hufford, Toledo; John H. Lazzari, Cleveland; Frank T. Moore, Akron; W. D. Nusbaum, Lancaster; William P. Yahraus, Canton; A. E. Rappoport, Youngstown; Walter A. Reese, Middletown; Carl A. Wilzbach, Cincinnati; W. E. Wygant, Mansfield; Robert E. Quinn, Chillicothe; William J. Flynn, Youngstown.

Members of the Cancer Coordinating Committee are: Drs. James, Hufford, Nusbaum, Rappoport, and Wilzbach, representing the Ohio State Medical Association; Dr. Hamilton B. G. Robinson, Columbus, representing the Ohio State Dental Association; Mr. Edgar O. Mansfield, Columbus, representing the Ohio Hospital Association; Dr. Ralph E. Dwork and Mr. William Veigel, representing the Ohio Department of Health; Mr. J. P. Kalina, Cleveland, representing the Ohio Division, American Cancer Society.

The report, which was approved by The Council, was based on the following excerpts from minutes of meetings of the two committees held on last November 3:

A detailed report with respect to the operation of the Ohio Cancer Registry compiled by Mrs. Nancy Lucas, Miss Polly Reish and Dr. Betty Coulter, of the Ohio Department of Health staff, and Mr. Veigel, was presented. Following is a summary of the report:

Summary Statement

Registered to date	(1956 cases)	3398	
On hand to be registered	(1956 cases)	495	3893
Registered to date	(1957 cases)	1268	
On hand to be registered	(1957 cases)	351	1619
Total number of follow-up inquiry reports sent out (1st 8 months of 1957 on 1956 cases):			2097
Total number not returned to date (24%)			517

At the present time there are 17 registries participating in the Ohio Cancer Registry, representing 27 hospitals in the following cities: Akron, Bay Village, Cleveland, Columbus, Cuyahoga Falls, Dayton, Elyria, Gallipolis, Lancaster, Mansfield, Martins Ferry, Portsmouth, Youngstown (St. Elizabeth and Youngstown Hospital Association), Zanesville (Good Samaritan and Bethesda).

Other Activities

During 1956 the basic record forms for Ohio Cancer Registry operation were revised and printed. These forms were then distributed to local cancer registries desiring to use them or participate in the Ohio Cancer Registry. In addition a procedures manual for local cancer registry operation was written, printed and distributed to participating registries.

There were talks made on cancer registry operation to several groups, including the Central and Northern Ohio Medical Record Librarians Associations and the executive secretaries of Ohio's local units of the American Cancer Society at their annual meeting.

Personnel participated in the preparation of educational material on the cancer registry for an exhibit at the Ohio State Medical Association meeting in Cleveland and personnel also manned the booth during meeting days.

Files and procedures were set up in the Ohio Cancer Registry office for the receipt and handling of cancer registry records from the local registries.

Some of the reasons given by physicians for non-interest in cancer registry establishment and participation in the Ohio Cancer Registry were discussed. Main objections to cancer registry establishment and participation raised by hospital personnel center around non-availability of required personnel, facilities and money to provide such.

Procedures Approved

It was reported that the Cancer Registry is accepting registry forms used by established local registries providing such forms contain required basic information even though they may be somewhat different in format from the state-wide forms. This met with the approval of the committee.

The committee expressed approval of the idea of a program to try to secure more cooperation from pathologists and radiologists in promoting

the establishment of local cancer registries and/or participation in the Ohio Cancer Registry.

Also, the committee expressed the view that it could see no harm in having the Central Registry provide duplicate sets of marginal punch card case data to local registries for statistical purposes until such time as the Central Registry is able to furnish tabulated data.

New Suggestions

Doctor Wentworth, chief of the Division of Chronic Illness, Ohio Department of Health, offered some ideas as to how the Ohio Department of Health might assist in the establishment of local registries and in promoting the program state-wide. Doctor Wentworth recommended: (1) That assistance to establish local registries be concentrated in selected areas instead of being scattered throughout the entire state, especially in communities which appeared not to be ready for a local registry; (2) That the State Department of Health sponsor a seminar in which the purposes and values of cancer registries could be explained; (3) That financial assistance might be given in the establishment of local registries where there was evidence that local funds could not be secured from the local cancer society or other sources. The committee expressed approval of Doctor Wentworth's recommendations, urging, however, that financial assistance be kept at a minimum as it would be better to have this project financed through local funds, if possible.

Ask for Legal and Ethical Opinions

A discussion was held on the question of "confidentiality" with respect to reports made by physicians to registries and by local registries to the Central Registry. In order to secure more information for consideration later by the committee, the committee, by official action, adopted the following motions:

(1) That The Council of the Ohio State Medical Association be requested to ask the Judicial Council of the AMA for a ruling as to whether there is a breach of medical ethics on the part of physicians who report information on cancer patients, without the specific consent of such patients and without being required to do so by law, to local cancer registries which registries in turn report the data to a state registry.

(2) That the chairman appoint a committee of not more than five from among the personnel of the co-ordinating committee to inquire into the legal aspects of reporting by physicians of information on cancer patients to local and state cancer registries and to prepare recommendations as to proper steps to make such procedures legal if the study should show that the reporting may be in violation of the laws pertaining to confidential and privileged communications.

Before the joint meeting adjourned a resolution expressing sympathy with respect to the death of Mr. L. E. Herget, Managing Director of the Ohio Division, American Cancer Society, and a member of the Co-ordinating Committee, was adopted and the Executive Secretary was instructed to convey this information to Mrs. Herget.

ACS Program Approved

Immediately following adjournment of the joint session, the Cancer Committee of the Ohio State Medical Association met to consider a report from Doctor James regarding the "Exfoliative Cytology Program," which is being sponsored nationwide by the American Cancer Society. A summary of this program follows: Mobilize support and interest of responsible pathologists; secure the support of the responsible component medical societies; recruitment and training of cyto-screeners; support and promote adequate laboratory and physical facilities where needed; inform all responsible physicians in the area about the program; get the public education program started at the proper time; provide continuity of examination; preserve the doctor-patient relationship; make the program self-supporting.

Doctor James stated that the American Cancer Society believes a motion picture on the cytology program should not be shown to lay groups in areas where services and facilities may not be adequate to carry out the program. He stated that the Cancer Society would like to have the cooperation of the Ohio State Medical Association and its local units on the entire matter. Following the discussion the committee voted cooperation with the national society. It endorsed the showing of the film in areas where facilities and services for carrying out the program are adequate, the question of adequacy to be determined by the medical advisory committee to the local cancer society. The committee suggested that in instances where facilities and services may be found inadequate that the local medical society be requested to cooperate in an effort to establish the necessary facilities and services.

Cincinnati ENT Course

The 22nd annual graduate convention in otology, rhinology and laryngology will be presented by the University of Cincinnati College of Medicine April 7-12. Details may be obtained from the Dean.

Proposed Amendments . . .

To By-Laws of Ohio State Medical Association Scheduled For Vote by The House of Delegates at the 1958 Annual Meeting in Cincinnati

ON authorization of The Council, a number of proposed amendments to the By-Laws of the Ohio State Medical Association will be submitted to the House of Delegates for action at the 1958 Annual Meeting, April 15-17, Cincinnati. In compliance with Chapter 15, Section 1, of the By-Laws, the proposed amendments are being published herewith in *The Journal.*

Proposed Amendment No. 1

This amendment proposes substitute wording for Sec. 4, Chapter 1 of the By-Laws pertaining to eligibility for membership in the Ohio State Medical Association. It clarifies the existing section on matters relating to foreign-born applicants for membership.

Be It Resolved that Sec. 4, Chapter 1 of the By-Laws be amended to read as follows:

Sec. 4. Eligibility. This Association shall consist of one class of members only viz: those members of component societies who have complied with the membership eligibility requirements of this section and whose past and current annual dues and assessments in this Association shall have been received from their respective component societies at the headquarters of this Association.

To be eligible to membership in this Association a person shall possess all of the following qualifications, to-wit:

(a) He must be a citizen of the United States, OR

He must have resided in the United States for at least one year, and he must have filed in an appropriate court of record a declaration of his intention to become a citizen of the United States, which declaration has not been withdrawn.

(b) He must be licensed to practice medicine and surgery by the licensing authority of the State of Ohio, OR

If he is currently serving as a hospital intern or resident within the State of Ohio and is not a member of a medical society of the District of Columbia or of any state or territory of the United States, he must be licensed to practice medicine and surgery by the licensing authority of the District of Columbia or of some state or territory of the United States.

(c) He must hold the degree of doctor of medicine or some foreign degree in medicine regarded by the Council of the Ohio State Medical Association as equivalent thereto.

Proposed Amendment No. 2

Amendment No. 2 proposes a new section in Chapter 4 of the By-Laws, relating to the introduction of resolutions in the House of Delegates. This proposal was suggested by the special committee which studied House of Delegates procedure. In effect, it provides resolutions must be filed with the Columbus Office 60 days in advance of the meeting so copies can be distributed to delegates; that no resolution may be introduced otherwise unless consent of two-thirds of the House of Delegates is obtained; that all resolutions must be introduced at the first session of the House of Delegates—a provision implied in the Order of Business but not specifically stated.

Be It Resolved, that Section 8 of Chapter 4 of the By-Laws be re-numbered so as to make it read "Section 9," and that a new section to be known as Section 8 of Chapter 4 of the By-Laws be enacted to read as follows:

Sec. 8. Resolutions. Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which such action is proposed to be taken; and promptly upon filing of any such resolution the Executive Secretary shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements of filing and transmittal shall have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at such meeting.

The Executive Secretary may cause to be published in *The Journal* in advance of such meeting of the House of Delegates any or all resolutions so filed with him; and upon the direction of the President or the Council the Executive Secretary shall cause to be so published such resolutions as the President or the Council may designate.

No consideration may be given, or any action taken, by the Committee on Resolutions or the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates.

Proposed Amendment No. 3

The Committee on Scientific Work has suggested that the committee be enlarged in order to provide more personnel to work on Annual Meeting details. Amendment No. 3 proposes changes in Sec. 2 and Sec. 4 of Chapter 9 of the By-Laws enlarging the committee to 10 members and outlining the way they shall be appointed.

Be It Resolved that Sec. 2 and Sec. 4 of Chapter 9 of the By-Laws be amended to read as follows:

Sec. 2. Method of Appointment. The standing committees shall be appointed by the President with the approval of the House of Delegates. Each year there shall be appointed one member for a term of five years

to each of the following standing committees: Committee on Public Relations and Economics, Committee on Education, and Judicial and Professional Relations Committee; and each year there shall be appointed two members for a term of five years to the Committee on Scientific Work. The President shall designate the chairman of each committee from among its members.

Sec. 4. Committee on Scientific Work. The Committee on Scientific Work shall consist of ten members. This committee shall have charge of the general arrangements for the annual meetings of the Association, including the scientific programs both for general sessions and such sections as may be authorized by Council, as well as the scientific exhibits.

On recommendation of this committee the Council shall appoint a general chairman of a Local Committee on Arrangements, who, after consultation with the president of the component society of the county in which the meeting is to be held, shall appoint and organize the personnel of the Local Committee on Arrangements from the members of the component society of such county. Through sub-committees of its choice the Local Committee on Arrangements shall have charge of all local arrangements, including provision of suitable meeting places, subject to the approval of the Committee on Scientific Work.

All receipts from the annual meeting shall be turned over to the Treasurer of this Association. All expenditures must be authorized in advance by the Auditing and Appropriations Committee.

With the advice of the President and subject to approval by Council, the Chairman of the Committee on Scientific Work may appoint such sub-committees as he may deem necessary and designate a chairman for each sub-committee so appointed.

Easter Seal Groups Break All Records In Number of Persons Helped

Breaking all previous records, more than 158,000 crippled children and adults received care from Easter Seal societies in 1957, and scores of new facilities and programs for the handicapped began operation, it was reported by the National Society for Crippled Children and Adults.

Dean W. Roberts, M. D., executive director of the Easter Seal Society, states in the organization's 1957 annual report titled "Steps to Rehabilitation" that greater service to the crippled than ever before in its 36-year history marked the strides made by the National Society during the past year.

Rehabilitation and treatment centers and programs of care, treatment and education now total approximately 1,400 and constitute an investment of more than $3,500,000 during the past year.

The Pan American Medical Women's Alliance will hold the Sixth Biennial Congress in Hotel McAllister, Miami, Florida, April 14-17, 1958. Medical women are invited to attend and to participate in the program. For further information please write to, Dr. Eva Cutright, 458 Beall Ave., Wooster, Ohio.



1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

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Proposed Auxiliary Amendments . . .

Suggested Changes in Constitution and By-Laws of Woman's Auxiliary To Be Voted on at the 1958 Annual Meeting Next April in Cincinnati

A NUMBER of proposed amendments to the Constitution and By-Laws of the Woman's Auxiliary to the Ohio State Medical Association will be voted on at the annual meeting of the Auxiliary April 15-17, Cincinnati. They have been prepared by a Revisions Committee and have been approved by the Board of Directors of the Auxiliary. The proposals are as follows, with the existing provisions presented first and the proposed changes following, in **blackface type**.

CONSTITUTION

ARTICLE 5

House of Delegates

The House of Delegates shall be the legislative body of this Auxiliary and shall consist of delegates elected by the component auxiliaries and the officers enumerated in Article 6.

Amend by adding the following sentence: "Past Presidents of the Woman's Auxiliary to the Ohio State Medical Association shall be considered members of the House of Delegates with all privileges except the right to vote."

ARTICLE 8

Fiscal and Membership Year

The fiscal and membership year of this Auxiliary shall be from January 1 to December 31. With respect to the terms of officers and committee members, the period from one annual meeting until the next shall be regarded as "one year."

Amend by striking out this article and substituting the following:

Membership Year

"The membership year of this Auxiliary shall be from January 1 to December 31. The term of office of all officers and committee members 'unless otherwise herein provided' shall be from one annual meeting until the next and this period shall be regarded as one year."

BY-LAWS

CHAPTER 1

Membership

Section 1. Eligibility. Wives, mothers, unmarried daughters and unmarried sisters of members in good standing of a component society of the Ohio State Medical Association and widows of members, who at the time of their decease were in good standing, shall be considered eligible for membership in this Auxiliary.

Section 2. Affiliation. A woman desiring to be a member of this Auxiliary must possess one of the qualifications enumerated in the preceding section and must first become a member of the component auxiliary of the county of her residence, if there is a component auxiliary in that county. A component auxiliary shall judge the qualifications of its members.

Section 3. Members-At-Large. A woman eligible for membership, residing in a county in which there is no organized auxiliary, may become a member-at-large of this auxiliary providing her request to become a member-at-large has the approval of the member of the Board of Directors of her district and she pays her state and national dues.

A member-at-large may be a delegate to the National Auxiliary, providing her husband is an active member of the American Medical Association.

Section 4. Disability. A woman qualified and eligible for membership in the Ohio State Medical Association shall not be eligible for membership in this Auxiliary. No one may be an active member of two component auxiliaries at the same time.

Section 5. Honorary Membership. Members of the Woman's Auxiliary to the Ohio State Medical Association who have rendered long and signal service may be eligible to become Honorary Members by action of the House of Delegates upon recommendation of the Board of Directors.

An Honorary Member shall enjoy all the privileges of Active Membership without payment of state dues. The State Auxiliary shall pay the dues of such members to the National Auxiliary.

Amend by striking out this entire Chapter and substituting the following:

CHAPTER 1

Membership

"Section 1. Active Members. Wives of members in good standing of a component society of

in common mixed infections
...tetracycline phosphate alone

PANMYCIN* Phosphate

for children:

PANMYCIN KM Syrup

TRADEMARK

BROAD-SPECTRUM TETRACYCLINE IN ITS MOST EFFICIENT FORM

Produces more tetracycline in the blood with no more in the dose. No calcium to depress blood levels.[1] Basic broad-spectrum therapy in bronchitis, pharyngitis, otitis media, tonsillitis, and other common respiratory infections.

1. Welch, H.; Wright, W. W.; and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 4:620, 1957.

in potentially serious infections
...tetracycline phosphate plus novobiocin

PANALBA*

for children:

PANALBA KM Granules

THE BREADTH OF PANMYCIN PHOSPHATE PLUS THE ANTIMICROCOCCAL DEPTH OF ALBAMYCIN†

Offers maximum antimicrobial action at the earliest possible moment. The antibiotic preparation of first resort in pneumonia of unknown etiology, carbuncles, multiple furunculosis, cellulitis, and infections resistant to previous therapy.

†TRADEMARK, REG. U. S. PAT. OFF. — THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

for the 7 monilia-susceptible types
...tetracycline phosphate plus nystatin

COMYCIN*

PANMYCIN PHOSPHATE PLUS THE ANTIMONILIAL PROTECTION OF NYSTATIN

The logical choice for patients requiring high doses of antibiotics or prolonged antibiotic therapy; for patients with previous monilial complications; for diabetics; patients on corticoids; the pregnant, debilitated, or elderly; and for infants, especially the premature.

Upjohn

The Upjohn Company, Kalamazoo, Michigan



THE CHOICE OF A SYSTEMIC ANTIBIOTIC IS A MATTER OF CLINICAL JUDGMENT

1. PANMYCIN PHOSPHATE IN COMMON MIXED INFECTIONS

USUAL DOSAGE: ADULTS: 250 mg. every 6 hours or 500 mg. every 12 hours. CHILDREN: Approximately 8 mg. per pound of body weight daily, in four equally divided doses every 6 hours, or two equally divided doses every 12 hours.

SUPPLIED: CAPSULES: 250 mg. in bottles of 16 and 100; 125 mg. in bottles of 25 and 100.

PANMYCIN KM SYRUP: Each teaspoonful (5 cc.) contains tetracycline equivalent to 125 mg. tetracycline hydrochloride, and potassium metaphosphate, 100 mg., mint flavor, in 2 fluidounce and pint bottles.

2. PANALBA IN POTENTIALLY SERIOUS INFECTIONS

USUAL DOSAGE: ADULTS: 1 or 2 capsules three or four times a day, depending on the type and severity of the infection. CHILDREN: Proportionately less.

SUPPLIED: Each powder-blue-and-brown capsule contains Panmycin (tetracycline) Phosphate complex equivalent to 250 mg. tetracycline hydrochloride, and Albamycin (as novobiocin sodium) 125 mg.; in bottles of 16 and 100.

Also available: **PANALBA KM GRANULES** (Pediatric). When reconstituted, each 5 cc. teaspoonful contains Panmycin equivalent to tetracycline hydrochloride, 125 mg. and Albamycin (as novobiocin calcium) 62.5 mg., and potassium metaphosphate 100 mg.; in pleasantly flavored vehicle. Dosage is based upon amount of tetracycline—6 to 8 mg. per pound of body weight per day in 2 to 4 equally divided doses.

3. COMYCIN FOR THE 7 MONILIA-SUSCEPTIBLE TYPES

USUAL DOSAGE: ADULTS: 1 or 2 capsules every 6 hours. CHILDREN: Proportionately less.

SUPPLIED: Each brown-and-pink capsule contains tetracycline phosphate complex, equivalent to 250 mg. tetracycline hydrochloride; nystatin 250,000 units. In bottles of 16 and 100.

Upjohn

The Upjohn Company, Kalamazoo, Michigan

the Ohio State Medical Association and widows of members of that Association or of any other state medical society who, at the time of their decease were in good standing, shall be considered eligible for membership in this Auxiliary.

"A wife must first bcome a member of the component auxiliary of the county in which her husband holds membership, and a widow of the component auxiliary of the county of her residence. A component auxiliary shall judge the qualifications of its members.

"No one may be an active member of two component auxiliaries at the same time.

"A woman eligible for membership, residing in a county in which there is no organized auxiliary, may become a member-at-large of this Auxiliary providing her request to become a member has the approval of the Director of her district and she pays her state and national dues.

"Nothing in this section shall be construed as retroactive.

"Section 2. Honorary Members. Members of the Woman's Auxiliary to the Ohio State Medical Association who have rendered long and signal service may become Honorary members by action of the House of Delegates upon recommendation of the Board of Directors.

"An Honorary member shall enjoy all the privileges of active membership without payment of state dues. The State Auxiliary shall pay the dues of such members to the National Auxiliary."

CHAPTER 2

Component Auxiliaries

Section 4. Fiscal Year. The fiscal and membership year of a component auxiliary shall be from January 1 to December 31.

Amend by striking out this section and substituting the following:

"Section 4. Membership Year. The membership year of a component auxiliary shall be from January 1 to December 31."

CHAPTER 4

House of Delegates

Section 4. Committees. To expedite proceedings of the House of Delegates the President, with the approval of the Board of Directors, shall appoint not less than 90 days prior to the annual meeting from among members of the House of Delegates, the following committees: Committee on Credentials, Committee on Resolutions, Committee on Tellers and Judges of Election; and other committees considered necessary by the President.

Amend by changing "ninety (90) days" to "sixty (60) days."

Section 6. Resolutions. All resolutions shall be referred without debate to the Committee on Resolutions which shall analyze them and report them back to the House of Delegates with such recommendations as may be considered by the committee to be advisable.

Amend by striking out this section and substituting the following:

Section 6. Resolutions. All resolutions shall be referred without debate to the Committee on Resolutions no later than thirty (30) days before the annual meeting. This committee shall analyze them and report them back to the House of Delegates with such recommendations as may be considered by the committee to be advisable.

"At the first business session only, emergency resolutions may be presented from the floor if consent has been given by the Advisory Committee and by a two-thirds vote of the members present and voting in the House of Delegates."

CHAPTER 5

Nomination, Elections and Terms of Office

Section 4. Vacancies. Any vacancies in office occurring between the annual meetings shall be filled by the President by appointment with the approval of the Board of Directors, except in the case of the President. In case of death or resignation of the President, the first Vice-President shall automatically become President and the vacancy thus occurring shall be filled in the usual manner.

Amend by striking out this section and substituting the following:

"Section 4. Vacancies. Any vacancies in office occurring between annual meetings shall be filled by the President by appointment with the approval of the Board of Directors, except in the case of President or President-Elect. In case of the death or resignation of the President, the first Vice-President shall immediately become President. In case of the death or resignation of the President-Elect, the Nominating committee shall meet within six (6) weeks of the time of vacancy and a meeting of the House of Delegates called for the purpose of electing a President-Elect."

Part II of the American Board of Obstetrics and Gynecology, oral and clinical examinations will be conducted at the Edgewater Beach Hotel, Chicago, May 7-17.

Medical Board Examinations . . .

Licenses To Practice in This State Are Sought by 123 M. D.'s Who Take December Examinations; Limited Practitioners Also Seek Ohio Licenses

THE State Medical Board of Ohio examined 123 graduates of medical schools who are seeking licenses to practice medicine and surgery in Ohio, during its examinations given in Columbus December 17-19, Dr. H. M. Platter, secretary of the Board, reported. Of that number 27 were graduates of U. S. and Canadian Schools, and 96 were graduates of schools in foreign countries. The Board also examined 20 graduates of osteopathic schools who are seeking to practice osteopathic medicine and surgery in Ohio.

In the limited practice branches, examinations were given to the following number of persons: Chiropody, 2; mechanotherapy, 9; chiropractic, 43; massage, 28; and cosmetic therapy, 3.

Results of the examinations were scheduled to be announced following a meeting of the Board on January 28, too late to be announced in this issue.

Following are the examination questions given to doctors of medicine:

Anatomy

1. Describe the extrahepatic biliary system. How are the ducts related to surrounding structures? A labeled drawing may be used.
2. Give the origin and course of the blood vessels directly supplying the: (a) appendix, (b) thyroid, (c) gallbladder, (d) spleen, (e) ovary.
3. Draw a section through the mature ovary to show its general histological structure, and label all the characteristic cell types.
4. Describe briefly the temporomandibular joint. In what direction does the joint usually become dislocated? Name the more important muscles acting through this joint.
5. If the ulnar nerve is severed in the midforearm: (a) What muscles are paralyzed? (b) What joints are affected by the paralysis? (c) What position does each of the affected joints assume?
6. To what structures is the VII cranial nerve distributed? List results of destruction of this nerve at or near the stylomastoid foramen. Why is this part of the nerve especially liable to injury?
7. List the supporting structures of the uterus. How are they arranged to carry out this function?
8. Describe the blood supply of the stomach. A labeled drawing may be used.
9. What structures, if any, are found in: (a) posterior cranial fossa, (b) femoral canal, (c) anterior-superior mediastinum, (d) left subphrenic space, (e) space of Retzius.
10. What is the average weight of: (a) the brain, (b) the liver, (c) the spleen, (d) the heart, (e) the Gasserian (semi-lunar) ganglion.

Physiology

1. Name four conditions which bring about a physiological polycythemia. Name four pathological states which produce polycythemia. What effect does high barometric pressure have on the number of red cells?
2. Name six factors which influence the flow of blood in the veins.
3. Discuss briefly the nervous control of the heart. State Marey's law.
4. Define bronchiectasis. What is the causation of bronchiectasis? Give its symtomatology.
5. Name four important factors in the formation of gallstones.
6. Give the functions of the gall-bladder.
7. Describe the three stages of deglutition.
8. Name four important factors in the physiological heat loss of the body.
9. In planning a diet, what requirements must be taken into account? Give the proper proportions of the three food stuffs in the adult diet.
10. Differentiate between ocular and labyrinthine nystagmus.

Bacteriology

1. What causative micro-organisms might be recovered from ulcero-membranous lesions of the pharynx?
2. What micro-organisms would you particularly look for in a chronic draining sinus of a flank?
3. What is the usual test for pathogenicity of staphylococci?
4. List likely methods of transmission of serum hepatitis virus.
5. Briefly outline the important types of food poisoning.

Diagnosis

1. Differentiate of the leg: (a) Phlebothrombosis, (b) Thrombo phlebitis, (c) Thromboangitis obliterans.
2. Give the etiology and signs of Parkinsonian Syndrome.
3. Differentiate between rheumatoid arthritis and gout.
4. How may osteitis deformans of the bone be differentiated from metastatic carcinoma and senile osteoporosis of the bone?
5. Give the principal signs and symptoms of acute anterior poliomyelites.
6. Differentiate between cardio spasm and hiatus hernia of the diaphragm.
7. Enumerate the causes of hemoptysis.
8. Differentiate the scalenus anticus syndrome from intervertebral disk.
9. Differentiate herpes zoster from radiculitis.
10. Name and describe the four types of psychoneurosis.

Chemistry

1. Discuss the plasma proteins as to their (a) Nature, (b) Principal groups.
2. In a jaundiced patient suspect for biliary obstruction, what laboratory tests would you make and what would be the findings if an obstructive mechanism is present?
3. In a male patient, age 65, with urinary frequency and a known residual urine of 300 plus cc, what laboratory investigation would be indicated? Why?
4. (a) In a normal subject, the average range of concentration of serum potassium is? (Express in mEq. per liter or mg. per 100 cc.) (b) Renal losses of potassium are exaggerated in what condition? Give

at least two. (c) Express in mEq. the amount of potassium usually ingested daily in food.
5. Give in outline form the principal factors in the etiology of iron deficiency anemia.

Materia Medica and Therapeutics

1. (a) Define radioactive element. (b) Give three uses of these elements.
2. (a) What is the dose of tincture of belladonna? (b) What indications show that the pharmacologic effect has been obtained?
3. Describe two safe and efficient emetics for a child.
4. Contrast the cardiac effects of quinidine and digitalis in the treatment of auricular fibrillation.
5. How is the action of drugs modified by: (a) age, (b) sex, (c) idiosyncrasy, (d) habits.
6. Enumerate and give treatment of the four major typical patterns of epilepsy.
7. Give three drugs affecting blood coagulation and the mechanism of action of one.
8. Outline the treatment of diffuse obstructive emphysema.
9. Outline the treatment of rheumatoid arthritis.
10. Outline the treatment of staphylococcus resistant septicemia.

Practice

1. In what classification of diseases does influenza belong? (a) What is the etiology of influenza? (b) The incubation? (c) The course and complications? (d) The prophylaxis? (e) The treatment?
2. In what classification of diseases does measles (Morbilli, Rubeola) belong? (a) Give the etiology of measles. (b) Give three diagnostic features of this disease.
3. Osteomyelitis: (a) Definition? (b) Etiology? (c) Symptoms? (d) Treatment?
4. Name five symptoms of tabetic neurosyphilis (tabes dorsalis, locomotor ataxia).
5. Define allergic rhinitis (hay fever). (a) Describe the treatment.
6. What is scurvy? (a) Etiology? (b) Symptoms? (c) Treatment.
7. Give five subjective and objective findings in gout and/or gouty arthritis.
8. Give the modes of entry of infectious hepatitis. (a) Give the management of infectious hepatitis.
9. Give the symptoms and physical findings of empyema.
10. Relate the management of infectious mononucleosis.

Pathology

1. With regard to rheumatic fever: (a) What is commonly considered to be the cause? (b) What anatomic sites are apt to be attacked? (c) What are the common laboratory aids in diagnosis?
2. With regard to silicosis: (a) What factors are necessary for causation? (b) What is the nature of and the effect of the pulmonary lesions? (c) What complicating diseases or processes often occur in the lungs? Elsewhere?
3. What are the dangers and complications of: (a) Gastric ulcer? (b) Duodenal ulcer?
4. At what two periods of life does polycystic disease of the kidney usually become manifest and what are the usual manifestations in each instance?
5. What conditions might cause a scrotal mass at age 45?
6. What is meant by carcinoma in situ?
7. List the usual results of parathyroid adenoma.
8. What is the common primary malignant tumor of bone, and what are the common sites and age of occurrence and usual outcome?
9. With regard to poliomyelitis: (a) What is the basis for the permanent paralysis which may result? (b) What is the basis for the improvement which may come during convalescence?
10. What are the dangers incidental to exposure to carbon tetrachloride?

Surgery

1. Compare the open versus closed treatment of burns, indicating specifically: (a) indications for each. (b) advantages of each. (c) differences, if any, in parenteral fluid requirements, narcotics, antibiotics for each, and (d) results.
2. A woman, 40 years of age, has a 2-3 cm. mass in one of her breasts: (a) what further information would you need to make a clinical diagnosis? (b) list (do not discuss) differential diagnostic considerations.
3. Define paralytic ileus. Give three common causes, and outline treatment.
4. Give causes and differential diagnosis of chronically enlarged lymph nodes of the neck.
5. Discuss symptoms, differential diagnosis and treatment of cholelithiasis.
6. Describe treatment of simple fracture of both bones of the leg, lower 1/3.
7. Name the complications of gastric and duodenal ulcer. Discuss one from the standpoint of diagnosis and surgical management.
8. Discuss surgical management of traumatic rupture of the kidney.
9. Indicate your preference between surgery and irradiation in treatment of the following and state reasons why: (a) basal cell carcinoma of the external ear, (b) squamous cell carcinoma of the cheek, 0.5 cm. from the eye, (c) Keratinization of the dorsum of the hand with squamous cell carcinoma. (d) basal cell carcinoma of the nose, (c) pigmented mole on sole of the foot.
10. List four important principles in early management of acute head injuries.

Obstetrics and Gynecology

1. A woman, aged 35 years, has had irregular bleeding for two weeks. There is a moderate fever and the leukocyte count is 15,000. Examination reveals a fluctuant, tender mass in the cul-de-sac. Name the two chief diagnostic possibilities and differentiate between them.
2. How should a post-partem hemorrhage be treated?
3. What conditions must be fulfilled before you may apply forceps?
4. Differentiate between appendicitis and right tubal pregnancy.
5. Outline proper procedures for handling a transverse presentation of the foetus.
6. Discuss the etiology, pathology and treatment of non-gonococcal cervical leukorrhea.
7. What are the dangers to mother and fetus involved in the use of pituitrin in (a) the first stage of labor? (b) the second stage of labor?
8. Discuss the diagnosis and treatment of pelvic endometriosis.
9. Give the diagnosis and treatment of dermoid cyst of the ovary.
10. How should eversion of the uterus be treated?

Specialties

1. Name five conditions which may cause wheezing in a two-year old child.
2. Outline the differential diagnosis between acute congestive glaucoma and acute irdocyclitis.
3. Outline the treatment of acute anuria.
4. Compare psoriasis vulgaris and lupus erythematosus as to similarities and differences: (a) clinically, (b) As to the effects of trauma, weather and ultraviolet rays.
5. State the possible complications as related to the eighth cranial nerve from the use of streptomycin and dihydrostreptomycin. (a) State the portion of

the eighth cranial nerve which is more apt to be affected from toxicity due to streptomycin. (b) State the portion of the eighth cranial nerve which is more apt to be affected from toxicity due to dihydrostreptomycin. (c) What determinations should be made prior to and during therapy with streptomycin or dihydrostreptomycin.

Preventive Medicine & Hygiene

1. How may a room recently occupied by a patient with scarlet fever be made safe for subsequent occupancy?
2. Define: (a) passive immunity, (b) toxin, (c) virus, (d) vaccine, (e) antigen.
3. Name four deficiency diseases and outline the methods of prevention of one of them.
4. Discuss the etiology, diagnosis and method of control of septic sore throat.
5. Give characteristics by which clostridium tetani is identified.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

December 18—L. John De Albuquerque, Cambridge, Univ. of Brazil; Edwin F. Aune, Gallipolis, Long Island College; Laurence H. Ballou, Akron, Univ. of Vermont; Norman R. Benner, Springfield, Jefferson Medical College; Daniel G. Bernoske, Tiffin, Indiana University;

Elmond L. Coffield, Medical College of Virginia; Olan T. Coffield, Univ. of Louisville; Melvin D. Cook, Akron, Univ. of Nebraska; Thomas V. Craig, Columbus, Indiana University; James H. Crawford, Columbus, Univ. of Minnesota; George Dimza, Univ. of Latvia; Paul F. Doege, Springfield, Harvard Medical School; William L. Driskill, Jr., Columbus, Medical College of Virginia;

Humberto C. Gonzalez, Youngstown, Stanford Univ.; Lewis J. Graham, Bellevue, Univ. of Rochester; Thomas C. Hadley, Toledo, Tufts University; Nancy H. Hinkle, Cincinnati, Univ. of Louisville; Samuel J. Hunter, Bellaire, Yale University; John A. Hyland, Youngstown, St. Louis University; Robert J. Kaufmann, Univ. of Illinois;

Robert J. Lancaster, Cleveland, St. Louis University; Tung K. Lin, Cleveland, Nat. Central University, Nanking, China; George N. Lipsky, Cleveland, State Univ. of Dnepropetrovsk, Ukraine, USSR.; Robert C. Long, Cleveland, Univ. of Kansas; Anthony S. Lupica, Tiffin, St. Louis Univ.;

Henry E. Maki, Bowling Green, Univ. of Michigan; Bohdan T. Nedilsky, Lima, Univ. of Prague, Czech.; John J. Ockuly, Toledo, Univ. of Louisville; Louis R. Putnam, Cincinnati, Columbia University; Kenneth F. Rupp, Creighton University; Franz B. Ruwe, Toledo, Univ. of Goettingen, Germany;

Robert K. Saylor, Cleveland, Univ. of Kansas; Mary A. Schmidt, Columbus, Univ. of Minnesota; Raymond L. Sheets, Jr., Columbus, Hahnemann Medical College; Reginald W. Shelby, Warren, Meharry Medical College; Ollie E. Southard, Columbus, Univ. of Pittsburgh; Judson D. Speer, Columbus, Albany Medical College; Jerome J. Stanislaw, Youngstown, St. Louis University; Joanna Sym, Cleveland, Univ. of Freiburg, Germany;

Lee H. Trachtenberg, Elyria, Univ. of Illinois; John J. Turner, Youngstown, Harvard Medical School; Peter Volodkevich, Elyria, Military Medical Academy of Leningrad, USSR; John R. Whitaker, Jr., Dayton, Univ. of Pennsylvania.

Several Physicians Named on Board And Advisory Committee of Mental Health Group

The newly organized Mental Health Federation, Inc., has announced a roster of its officers, trustees and members of the professional advisory committee. Included on the roster are two physicians on the board of trustees and six physicians on the professional advisory committee.

The Honorable Charles Sawyer, Cincinnati, president of the organization, announced that the National Association for Mental Health at its meeting in Atlantic City, November 23, voted to make Mental Health Federation the Ohio Division of the National Association for Mental Health. Headquarters office of the federation is 2111 Union Central Building, Cincinnati 2.

Officers in addition to the president are: John V. Fels, Cleveland, vice-president; Mrs. Fred Lazarus, Jr., Cincinnati, vice-president; Robert Nekervis, Columbus, treasurer, and Mrs. George McCandless, Hamilton, secretary.

Members of the Board of Trustees are: Mrs. Howard Bevis, Columbus; Neale Bogner, Oxford; James Chapmen, Cleveland; Honorable Stephen C. Colopy, Akron; Rev. John F. Duffy, Jr., Akron; Mrs. Ethel Fridline, Canton; William Gillie, Columbus; Mrs. Robert N. Gorman, Cincinnati; Mrs. Robert Hays, Shaker Heights; Anthony Poss, Lakewood; Russel G. Saxby, Columbus; Dr. John J. Schwab, Gallipolis, and Dr. Richard E. Wolf, Cincinnati.

Members of the Professional Advisory Committee are: Dr. Douglas Bond, Cleveland; Dr. Howard D. Fabing, Cincinnati; Dr. Charles E. Holzer, Gallipolis; Dr. Maurice Levine, Cincinnati; Dr. John A. MacLeod, Cincinnati; and Dr. Ralph Patterson, Columbus.

In Memoriam . . .

Harry V. Paryzek, M. D., Cleveland; Past-President of the Ohio State Medical Association, an outstanding physician and leader in medical organization work for many years, died on January 20 at the age of 66. Dr. Paryzek was a graduate of Western Reserve University School of Medicine, 1915, a member of the Ohio State Medical Association and the American Medical Association; a diplomate of the American Board of Internal Medicine; Fellow of the American College of Physicians.

A native of Cleveland, Dr. Paryzek took intern and residency training at Lakeside Hospital and entered military service in 1917, serving overseas for two years as captain in War Base Hospital Unit No. 4 (Lakeside Unit) and Mobile Hospital Unit No. 5. Returning to Cleveland after his service overseas, Dr. Paryzek entered private practice and was distinguished by being named director of Medicine at St. Alexis Hospital and chief of staff.



Dr. Paryzek

His interest in organization work was recognized early when he was elected to the Board of Directors of the Academy of Medicine of Cleveland in 1924, a responsibility he held until 1938. In 1933 he served as President of the Academy. His first office on the state level was that of chairman and secretary of the OSMA Section on Medicine. In 1932 he was elected a member of The Council of the State Association, representing the Fifth District. He declined re-election after two years for health reasons, but in the Fall of 1937 returned to fill the unexpired term of Dr. A. A. Jenkins, upon the latter's death. In 1938 he accepted appointment to the special Coordinating Committee authorized by The Council to engage in a comprehensive study of the distribution of medical services in the state.

The high honor of being named President-Elect of the State Association came in 1940, after which he served as President for the 1941-1942 term of office. His service to the State Association continued when he was named chairman of the OSMA Committee on Chronic Illness, a post he held at the time of his death.

His record shows that he served in some 40 positions of responsibility as officer or committeeman and that his interests were in civic as well as professional activities. Gardening was one of his hobbies together with an active participation in several local gardening clubs.

Surviving are his widow, two daughters and several grandchildren.

Jacob P. Allen, M. D., Williamsburg; Cincinnati College of Medicine and Surgery, 1894; aged 86; died December 19; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Allen had been a practicing physician in Clermont County since the turn of the century and participated in numerous community activities. He was a member of the Methodist Church and the Masonic Lodge, Surviving are his widow and two sons.

Nathaniel J. Broughton, M. D., Lorain; Meharry Medical College, Nashville, 1905; aged 79; died December 28. Dr. Broughton practiced medicine in Birmingham, Ala., until 1949 when he retired and moved to Lorain. Surviving are his widow and two daughters.

Harold H. Brueckner, M. D., recently of Canton; University of Michigan Medical School, 1932; aged 50; died December 8; member of the Ohio State Medical Association, the American Medical Association, the American College of Chest Physicians and the American Trudeau Society. For 11 years Dr. Brueckner was superintendent of the Molly Stark Hospital in Canton. He resigned November 1 because of ill health and moved his family to Ann Arbor. Surviving are his widow, two sons and two daughters.

Rice Kemper Evans, M. D., Dayton; Miami Medical College, Cincinnati, 1902; aged 78; died November 29; former member of the Ohio State Medical Association. A native of Dayton, Dr. Evans began his practice in Franklin. He spent 20 years in England in the American consular service before he moved to Dayton in 1930 and became associated with the Master Electric Company. Survivors include a son and two daughters.

Francis F. Field, M. D., Marion; Starling Medical College, Columbus, 1898; aged 82; died December 11. Dr. Field practiced in the Meeker community from 1915 to 1936 when he retired and moved to Marion. Survivors include his widow, two sons, a daughter and a sister.

Louis H. Frechtling, M. D., Hamilton; University of Illinois College of Medicine, 1903; aged 77; died December 10; former member of the Ohio State Medical Association. Dr. Frechtling

was in private practice in Hamilton from 1906 until 1919. In the latter year he became director of the Champion Paper and Fibre Company's medical department. He was active in numerous community affairs both professional and civic. Activities included participation in such projects as the YMCA, Community Chest, local Board of Education, and many others. He was a member of several Masonic bodies. Survivors include his widow, a daughter, two sons and three sisters.

Mildred White Gardiner, M. D., Middletown; Ohio State University College of Medicine, 1925; aged 65; died December 21; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. Dr. Gardiner went to medical school and obtained her degree after her husband died leaving her with two children. She had been a practicing physician in Middletown for about 25 years. Surviving are her son, Dr. Alfred Gardiner, Cincinnati, a daughter and two sisters.

Charles E. Geiser, M. D., Cincinnati; Pulte Medical College, Cincinnati, 1901; aged 79; died December 10. Dr. Geiser had been a parcticing physician in Cincinnati for more than a half century. Affiliations included membership in the Masonic Lodge. Surviving are his widow, a son and a daughter.

Jerome Giuseffi, Jr., M. D., Cincinnati; University of Cincinnati College of Medicine, 1942; aged 39; died January 2; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery; member of the Central Surgical Society and the Cincinnati Surgical Society. Dr. Giuseffi, after completing his internship, served three years in the Navy Medical Corps. Since the war he had been a practicing physician and assistant professor of surgery at the University of Cincinnati College of Medicine. He was one of the founders of the Blood Vessel Bank at General Hospital. Survivors include his widow, four sons, his parents and two sisters.

William T. Haire, M. D., Cleveland; Vanderbilt University School of Medicine, 1925; aged 58; died December 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Haire had been a practicing physician for many years in Cleveland. During World War II he served in the Army Medical Corps with the rank of major. Affiliations included memberships in the Elks Lodge and Phi Delta Theta. Surviving are his widow, a son, a brother and a sister.

Fred B. Harrington, M. D., Steubenville; University of Buffalo School of Medicine, 1914; aged 69; died December 24; member of the Ohio State Medical Association, the American Medical Association and the Industrial Medical Association. A veteran of World War I, Dr. Harrington became chief surgeon for the Weirton Steel Company in 1919 and remained in that capacity until 1936, after which he continued with the firm on a part-time basis. He was a resident of Steubenville for 21 years. Active in professional and civic organizations, he was a member of the Elks Club and several Masonic bodies. Surviving are his widow, a son, two daughters and three sisters.

Fred H. J. Heyse, M. D., Cleveland; medical degree from the Hessische Ludwigs University, Germany, 1922; aged 62; died December 31; former member of the Ohio State Medical Association. A native of Germany, Dr. Heyse came to this country shortly after World War I. He was a practicing physician in the West Side of Cleveland for 29 years. Survivors include his widow and two sons, one of whom is Dr. Walter E. Heyse, a resident at University Hospitals in Cleveland.

Paul J. Lee, M. D., Lucas; University of Louisville School of Medicine, 1933; aged 52; died December 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Lee had been a practicing physician in Lucas for approximately 20 years. He was a veteran of World War II having gone into service with a National Guard unit in 1941. Activities included service on the Richland County Health Department, the local school board and the Board of Public Affairs in Lucas. Surviving are his widow, a daughter, a foster son and a brother.

John LoCricchio, M. D., Youngstown; University of Michigan Medical School, 1931; aged 53; died December 28; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Clinical Pathologists; diplomate of the American Board of Pathology. Dr. LoCricchio had been pathologist at St. Elizabeth Hospital since 1950. Earlier he had been director of laboratories at St. Rita's and Memorial Hospitals in Lima. In the interim he practiced for a short time in Sharon, Pa., and Bridgeport, Conn., before he returned to Ohio. He was a member of the Presbyterian Church and the Masonic Lodge. Surviving are his widow, a son, two daughters, a brother and two sisters.

Joseph E. McClelland, M. D., Cleveland; Western Reserve University School of Medicine, 1912; aged 70; died December 17; member of the

Ohio State Medical Association, American Medical Association, American Academy of Pediatrics and diplomate of the American Board of Pediatrics. Dr. McClelland began private practice in Cleveland after serving in the Army Medical Corps during World War I. He was for many years associate clinical professor of pediatrics at Western Reserve and recently was named emeritus professor. Affiliations included memberships in the Medical Arts Club and the Pasteur Club of Cleveland. Survivors include his widow and two sons, Dr. Charles Q. and Dr. J. Gibson McClelland, both of Cleveland; also a sister and a brother.

Howard D. McIntyre, M. D., Cincinnati; Ohio State University College of Medicine, 1920; aged 65; died December 22; member of the Ohio State Medical Association, the American Medical Association, the American Psychiatric Association, the Central Neuropsychiatric Association; diplomate of the American Board of Psychiatry and Neurology; past-president of the Cincinnati Society of Neurology and Psychiatry. Dr. McIntyre was a practicing physician for many years in Cincinnati and clinical professor of neurology at the University of Cincinnati. He also served as consultant to several railroads. In addition to his professional affiliations, he was a member of the Cincinnati Country Club, the Queen City Club, the University Club and the Literary Club. Surviving are his widow, Dr. Aurelia P. McIntyre, three daughters and two sons, one of whom is Dr. Clifford McIntyre, of Ft. Lauderdale, Fla.

Daniel E. Miller, M. D., Dayton; Miami Medical College, Cincinnati, 1899; aged 90; died December 9; former member of the Ohio State Medical Association. Dr. Miller served all of his professional career of more than a half century in Dayton. He was a member of Sigma Chi and several Masonic bodies.

Samuel C. Nieman, M. D., Los Angeles, Calif.; Medical College of Ohio, Cincinnati, 1901. Dr. Nieman practiced in Cincinnati from 1908 to 1915.

Richard A. Niple, M. D., Portsmouth; Ohio State University College of Medicine, 1936; aged 47; died December 27; former member of the Ohio State Medical Association. Dr. Niple had been serving for two years on the staff of Portsmouth Receiving Hospital. He formerly practiced in Flushing and St. Clairsville. A veteran of World War II, he participated in the D-Day invasion as a member of the Army Medical Corps. His parents and a brother survive.

William H. Rheinfrank, M. D., Perrysburg; University of Michigan Medical School, 1894;





aged 86; died December 11; member of the Ohio State Medical Association and the American Medical Association through 1956; Fellow of the American College of Surgeons. A native of Perrysburg, Dr. Rheinfrank served all of his professional career there, where he was formerly associated with his father, the late Dr. J. H. Rheinfrank. His practice included operation of the Rheinfrank Hospital in Perrysburg. Dr. Rheinfrank was a member of the Masonic Lodge and the Presbyterian Church. Surviving are his widow; his son-in-law and daughter, Dr. and Mrs. Norman Foley, of Toledo; and a brother.

Frieda E. Weiss Robertson, M. D., Cleveland; Cleveland-Pulte Medical College, 1903; aged 80; died December 23. A native of Germany, Dr. Robertson came to this country in 1903. She practiced in Cleveland until her retirement about 10 years ago. Her husband, Albert Robertson, died in 1942. A foster daughter survives.

William J. Rogers, M. D., Cleveland; Western Reserve University School of Medicine, 1914; aged 69; died December 22; member of the Ohio State Medical Association. Dr. Rogers had been a practicing physician in Cleveland, principally on the West Side for some 40 years. He is survived by his widow and a son.

Horace G. Stewart, M. D., Cincinnati; Johns Hopkins University School of Medicine, 1918; aged 68; died December 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Stewart had been a practicing physician in Cincinnati since 1923. His pediatric practice was unique in that he never maintained an office. A bachelor, he is survived by a brother and two sisters.

Samuel Philip Studybaker, M. D., Columbus; Hahnemann Medical College and Hospital of Philadelphia, 1947; aged 35; died December 20 in an automobile accident; member of the Ohio State Medical Association and the American Medical Association. After serving as captain in the Air Force during 1951 and 1952, Dr. Studybaker went into practice in his home town of Miamisburg. He had been a resident in anesthesiology at University Hospital since July. Survivors include his widow, a son, a daughter and his parents.

Rabies Conference

Ohio is included in the area comprising the Great Lakes Regional Rabies Conference to be held at the LaSalle Hotel, Chicago, February 19-20. Physicians, veterinarians and public health officials are on the program. Details may be obtained from 13 N. Wells St., Room 802, Chicago 6.

Do You Know? . . .

Dr. J. Howard Holmes, Toledo, has been reappointed by Governor C. William O'Neill, to the Ohio Public Health Council for a term ending June 30, 1964.

* * *

A jury awarded two polio victims and their parents $147,300 from Cutter Laboratories on the grounds that the children contracted the disease after receiving polio vaccine manufactured by the firm. The plaintiffs had asked $360,000. Thirty-one other suits asking ten million dollars damages have been filed against Cutter.

* * *

Dr. Harry H. Botts, retiring manager of the Veterans Administration Hospital, Chilicothe, and Mrs. Botts were honored when 194 persons gathered for dinner at the local Elks Hall. In government service for more than 35 years, Dr. Botts was active in local civic affairs. The couple will make their home in Florida.

* * *

Dr. Roy Hertz, former Clevelander, and now chief of endocrinology, National Cancer Institute, Bethesda, Md., was presented the Anne Frankel Rosenthal Memorial Award at the recent meeting of the American Association for the Advancement of Cancer.

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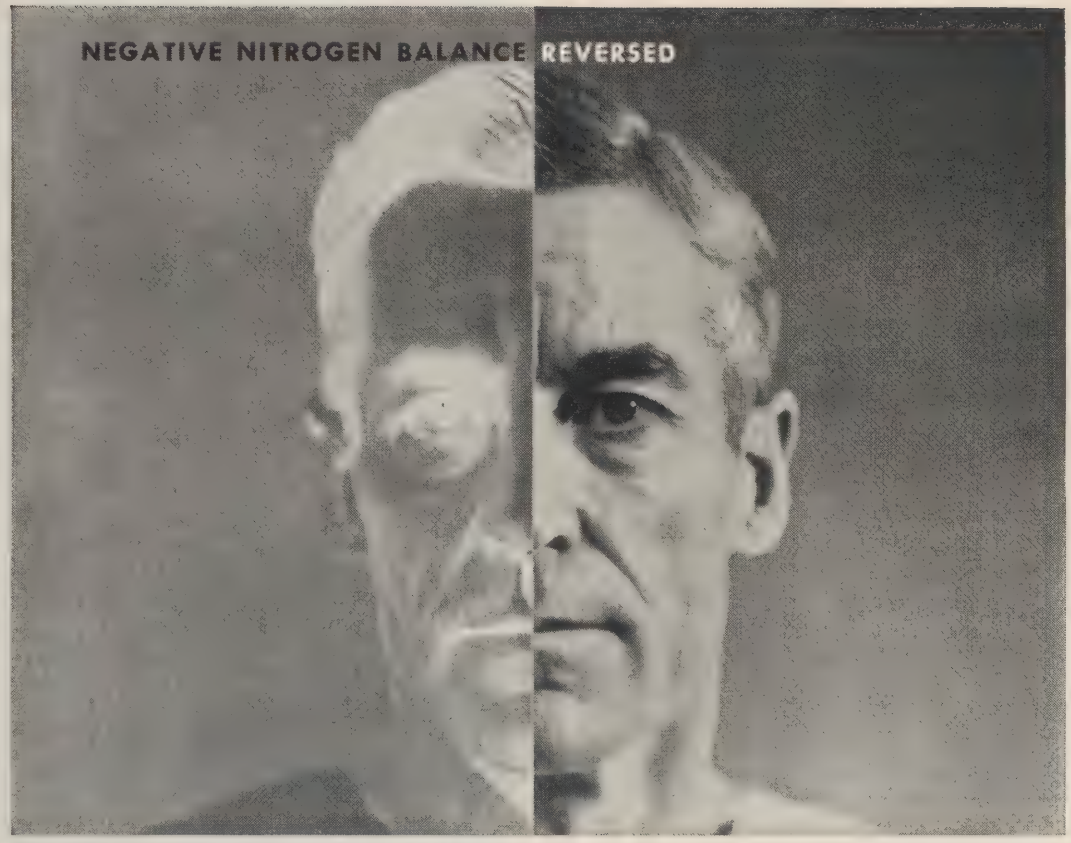
Dr. Leonard L. Lovshin, a member of the staff of the Department of Internal Medicine at the Cleveland Clinic, addressed the Ft. Steuben Academy of Medicine following a dinner at the Ft. Steuben Hotel at Steubenville, December 9.

* * *

Dr. John F. Meuller, Cincinnati, assistant professor of medicine at the University of Cincinnati, has been elected president of the Midwestern Section of the American Federation of Clinical Research.

To See Medicolegal Film

The AMA Law Department announces that "traumatic neurosis" will be the subject of the third film in the series of six medicolegal films to be produced in cooperation with the Wm. S. Merrell Company of Cincinnati. The film will delve into some of the problems that face psychiatrists and neurologists in identifying patients' psychoses resulting from various traumatic experiences. Physicians will have an opportunity to see the premiere showing of this film at the AMA's Annual Meeting in June in San Francisco.



Nilevar®

stimulates protein synthesis, corrects negative nitrogen balance

Increased nitrogen loss, with resulting negative nitrogen balance, occurs in infection, trauma, major surgery, extensive burns, certain endocrine disorders and starvation and emaciation syndromes. The intrinsic control of protein metabolism is lost and a protein "catabolic state" occurs. A patient requiring more than ten days of bedrest usually has had sufficient metabolic insult[1] to precipitate such a "catabolic" phase.

Nilevar (brand of norethandrolone) has been used in patients with varied conditions including hyperthyroidism, poliomyelitis, aplastic anemia, glomerulonephritis, anorexia nervosa and postoperative protein depletion. The patients gained weight and felt better. It was concluded[2] that "the drug certainly caused a reversal of rather recalcitrant or progressive catabolic patterns of disease."

Nilevar is unique among anabolic steroids in that androgenic side action is minimal or absent.

The suggested adult dosage is three to five tablets (30 to 50 mg.) daily. For children 1.5 mg. per kilogram of weight is recommended.

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Research in the Service of Medicine.

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1. Axelrod, A. E.; Beaton, J. R.; Cannon, P. R., and others: Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Incorporated, (March) 1954, p. 100.

2. Proceedings of a Conference on the Clinical Use of Anabolic Agents, Chicago, Illinois, G. D. Searle & Co., April 9, 1956, pp. 32-35.

SEARLE

Ohio State Heart Association Schedules Program in Cincinnati, April 14

A panel discussion on Arteriosclerosis will be featured at the annual meeting of the Ohio State Heart Association, on Monday, April 14, the week of the Annual Meeting of the Ohio State Medical Association, at the Sheraton-Gibson Hotel in Cincinnati, Dr. John W. Martin, Cleveland, program chairman of the OSHA, has announced.

This scientific session, to which all physicians are invited, will be moderated by Dr. Irvine H. Page, of the Cleveland Clinic. Other participants will be Dr. Edgar V. Allen, Mayo Clinic, Rochester, Minn., Dr. Jules Hirsch, Rockefeller Institute, New York City, Dr. Johnson McGuire, Cardiac Laboratory, University of Cincinnati, and Frederick J. Stare, Ph. D., Department of Nutrition, Harvard University.

The session will run from 2:00 p. m. to 4:30 p. m. Questions on any aspect of Arteriosclerosis, which a physician may wish discussed by the panel, are solicited and should be addressed in advance of the meeting to the Ohio State Heart Association, 131 E. State St., Columbus 15, Ohio.

A Community Health Session on research will run concurrently with the scientific session for physicians.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since December 1, 1957. The list shows the County in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County

Jack H. Berman, Cleveland
Esque Crawford, Cleveland
Milton D. Klein, Cleveland
Grace E. Lindsay, Cleveland
Bruce R. Marshall, Cleveland
Williams V. Martinez, Cleveland
Francesco Paino, Cleveland
Daniel E. Platt, Cleveland
Paul R. Pollack, Cleveland
Edward C. Ryan, Cleveland

Jefferson County

Jack M. Grant, Wintersville
Elver D. Lee, Steubenville
Jonathan Yobaggy, Steubenville

Medina County

Hilaire Gaudreault, Brunswick
Myrl A. Nafziger, Wadsworth
Vincent T. Wrobel, Brunswick

Montgomery County

George E. Baujan, Dayton
William O. Cass, Dayton
Stuart M. Denmark, Dayton
Richard M. Haskins, Dayton
Owen Hughes, Dayton
Michael M. Jaller, Dayton
Frederic Maccabe, Jr., Dayton
Joseph R. McWhirt, Dayton
John L. Pruzzo, Dayton
John M. Roll, Dayton
Kent K. Scholl, Dayton
Richard A. Serbin, Dayton
Phillip D. Sloan, Dayton
John R. Strawsburg, Dayton
Gerard A. Weigel, Dayton
John D. Welsh, Miamisburg
Robert A. Wickham, Vandalia
Coleman B. Witt, Dayton

Dr. J. Martin Byers, of Greenfield, has been advanced to the rank of lieutenant colonel (reserve) in the 37th Infantry Division, Ohio National Guard.

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'Cardilate' tablets  shaped for easy retention in the buccal pouch

"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

* 'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored



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Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

Dr. Richard Carr, Williamsburg, was elected president of the Clermont County Medical Society at a meeting held on December 4 at the D-X Ranch. Also elected were Dr. C. F. Barber, of Felicity, as vice-president; and Dr. Harry M. Breuer, of New Richmond, as secretary and treasurer.

The Clermont Medical Society currently has 22 members.

Dr. Carr succeeds Dr. Charles M. Simmons, of Bethel, as president.—*Clermont Sun.*

The January 15 meeting of the Society was held at the Millcroft Inn, Milford, with Dr. James MacMillan as host. Speaker was Dr. Sanford Courter, Cincinnati, who discussed cardiac irregularities.

CLINTON

The 1958 officers of the Clinton County Medical Society are the following: President, Dr. Roy D. Goodwin; vice-president, Dr. Robert M. Cronebaugh; secretary-treasurer, Dr. H. Richard Bath. Dr. E. K. Yantes was elected delegate and Dr. R. R. Buchanan, alternate.

"By a vote of 22 to 1, the Clinton County Medical Society disapproved the inclusion of physicians under the Social Security Act at their meeting January 7.

"Dr. Frank Mayfield visited and gave a talk on 'Association of Physicians.' Dr. Ellis of Xenia talked on 'Group Practice'."—Edmond K. Yantes, M. D.

HAMILTON

"The Rational Handling of Diabetes," was the topic for the January 21 meeting of the Academy of Medicine of Cincinnati. The speaker was Dr. Rachmiel Levine, chairman of the Department of Medicine and director of the Department of Metabolic and Endocrine Research, Michael Reese Hospital, and professorial lecturer, Department of Physiology, University of Chicago.

The Cincinnati Surgical Society met on January 8 in the Queen City Club and heard a discussion by Dr. Lester R. Dragstedt, professor of surgery, University of Chicago, whose subject was "A New Concept of the Pathogenesis of Gastric and Duodenal Ulcers."

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CHAMPAIGN

The annual Christmas dinner and party of the Champaign County Medical Society was held at the Urbana Country Club Wednesday evening, December 11.

After dinner Dr. John Towle acted as master of ceremonies for the evening program.

Dr. T. E. Richards, Dr. J. R. Polsley, Dr. William Pudvan and Dr. J. K. Pond gave a skit entitled, "This Is Your Life, Dr. Forrest Lowry."

A gift exchange was held following the program.—*Urbana Citizen.*

MIAMI

"Prolonged Labor and Its Management," was the subject discussed by Dr. Harry E. Ezell, Columbus, who is on the obstetric and gynecologic staff at University Hospital. The meeting was held at the Dettmer Hospital, Troy, followed by dinner.—*MCMS Bulletin.*

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

The annual dinner dance of the Academy of Medicine of Lima and Allen County was given on December 10 at the Shawnee Country Club. The better part of a page in the *Lima Citizen* was devoted to reports and pictures of the event. Among guests were Dr. James R. Jarvis, Van Wert, Councilor of the Third District, and Mrs. Jarvis.

CRAWFORD

Members of the Crawford County Medical Society and of the North Central Ohio Academy of General Practice, along with the Auxiliary to the Crawford County Medical Society, enjoyed a joint meeting and dinner at the Galion Country Club December 13. Approximately 60 members were in attendance.

Dr. Charles J. Griebling, retiring president of the County Society, presided and introduced Dr. Merit Marshall, Academy president, who in turn presented the guest speaker, Dr. J. A. Whieldon. The topic "Morals and Psychiatry," was given in an interesting manner by Dr. Whieldon, who is professor at Ohio State University Medical School.

New officers elected to head the North Central Ohio Academy for the coming year were president, Dr. D. D. Dibler, Bucyrus; president-elect, Dr. Griebling; secretary-treasurer, Dr. Malcolm E.

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Switzer; and member of the executive committee, Dr. Robert Gray, Prospect.

Heading the Crawford County Medical Society will be Dr. T. D. Sawyer, president, Dr. H. M. Brooks, vice-president, and Dr. R. D. Myers, secretary-treasurer, all of Crestline. Delegate and alternate to the state convention will be Dr. Carl Ide of Bucyrus and Dr. B. M. Mansfield, Galion. Dr. E. C. Brandt, Crestline, was elected to the board of censors.

Mrs. Martin Horowitz, unable to be present because of illness, is president of the County Medical Auxiliary.

Arrangements for the evening were made by Dr. and Mrs. C. J. Griebling and Dr. Martin M. Horowitz.—*Galion Inquirer.*

HANCOCK

Members of the Hancock County Medical Association entertained their wives at a dinner and dance December 17 at the Findlay Country Club.

Speaker for the dinner was Dr. Allan C. Barnes, head of the department of obstetrics and gynecology at Western Reserve, who spoke on Diagnosis of Retrospect." Dr. R. Grant Janes, president of the Association, presided at the dinner and welcomed the 40 couples in attendance. Dr. Marion F. Detrick Jr. introduced the speaker. Dr. M. W. Feigert was program chairman.

During a business session Dr. F. M. Wiseley was elected president of the society. Dr. W. E. Brown was elected vice-president; Dr. B. H. Saunders was re-elected secretary-treasurer. Dr. Lena S. Enright was elected to the credentials committee and Dr. H. K. Treece, Arlington, was elected delegate to the Ohio State Medical Association Convention.

Music for dancing was provided by the Lamp Lighters. A yuletide theme was used in the decorations.—*Findlay Republican Courier.*

LOGAN

Dr. Frederick Kaylor, Bellefontaine, was chosen president of the Logan County Medical Society succeeding Dr. Charles Thompson, West Mansfield, at the group's December dinner meeting at Mary Rutan Hospital.

Dr. Paul Hooley, DeGraff, was re-elected vice-president and Dr. Charles Browning, Bellefontaine, was re-elected secretary-treasurer.

Drs. W. E. Yingling and G. A. Edwards, of Lima, discussed infections of the middle-ear, their complications and treatment.—*Bellefontaine Examiner.*

SENECA

Dr. Harry C. Ulicny, Fostoria, was elected president of the Seneca County Medical Society, succeeding Dr. Leonard Gaydos. Tiffin, at a

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dinner meeting of the organization at the Shawhan hotel, Fostoria, in December.

Dr. Thomas Watking, Tiffin, is vice-president, and Dr. Emmet Sheeran, Fostoria, is secretary-treasurer.

Dr. Olgierd Garlo and Dr. O. G. Burkart, Jr., became members of the society. Dr. Gaydos presided at the meeting.—*Fostoria Review Times.*

Fourth District

(COUNCILOR: PAUL E. ORR, M. D., PERRYSBURG)

LUCAS

The January schedule of the Academy of Medicine of Toledo and Lucas County included the following features:

January 10—General Practice Section: "Plastic Surgery," an afternoon and evening postgraduate course with papers presented by Dr. John C. Kelleher, Dr. Henry McWhorter and Dr. James Sullivan.

January 15—56th Annual Meeting of the Academy, Commodore Perry Hotel. Included on the program were a social hour, banquet and evening program. Guest speaker was Oliver C. Schroeder, Jr., director of the Law-Medicine Center, Western Reserve University School of Law.

January 24—Surgical Section: "The Diagnosis and Treatment of Acquired and Congenital Heart Disease," Dr. Earle B. Kay and Dr. Henry A. Zimmerman, Cleveland.

A coming event in Toledo is the Inter-Hospital Postgraduate Lecture Series sponsored by the Medical Advancement Trust of Maumee Valley Hospital and the Northwestern Ohio Heart Association on Thursday and Friday, February 13 and 14. Speaker for the occasion will be Dr. E. M. Papper, director of the anesthesiology service, Presbyterian Hospital, New York City. The theme of the series will be "Physio-Pathology of the Cardio-Respiratory Systems."

OTTAWA

Dr. Cyrus Wood was elected president, Dr. Gordon Ley, vice-president and Dr. Robert Minick, of Oak Harbor, secretary-treasurer at the December meeting of the Ottawa County Medical Society held in the National Bank Building.

Following the business meeting, the doctors joined the Auxiliary at the home of Miss Florence Specht, hospital superintendent, for a Christmas party with exchange of gifts.—*Port Clinton Republican-Herald.*

PUTNAM

Guest speaker for the November 5 meeting of the Putnam County Medical Society was Dr. Vernon A. Noble, Lima, who discussed "Treat-

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ment of Vaginitis." The meeting was held at Hotel Dumont, Ottawa.—H. N. Trumbull, M. D., correspondent.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

A combined meeting of the Academy of Medicine of Cleveland and the Cleveland Bar Association was held at the Manger Hotel in Cleveland on December 5. Speaker for the occasion was Catherine Drinker Bowen, writer of such successful books as *Yankee from Olympus.*

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Dr. Andrew A. Detesco was officially elected president of the Mahoning Medical Society at the annual election of officers in the Elks' Club Tuesday evening, succeeding Dr. Stephen W. Ondash. Dr. M. W. Neidus was elected president-elect.

Other new officers include Dr. A. K. Phillips, secretary; Dr. F. G. Schlecht, treasurer; Dr. H. T. McGregor, three-year delegate to the Ohio State Medical Association. Alternate delegates elected include Dr. C. C. Wales, Dr. C. W. Stertzbach and Dr. John J. McDonough. Following the business session a buffet supper was held.—Clyde K. Walter, M. D., correspondent.

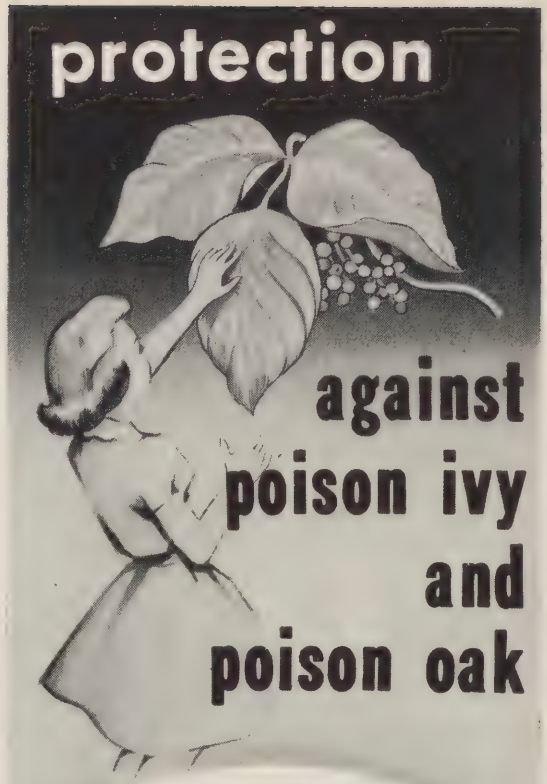
STARK

Dr. Roy H. Clunk, Massillon physician, was elected president of the Stark County Medical Society at its pre-holiday Annual Meeting at the Belden Hotel, Canton. The 300-member organization of Stark County doctors selected Dr. Clunk to succeed Dr. Robert Tschantz, who also was recognized at the meeting for his accomplishments as President during 1957.

Other officers selected include: Dr. John R. Seesholtz, Canton, president-elect for 1959, and Dr. Murray W. Scott, Jr., Canton, secretary-treasurer.

The Society also appointed the following delegates to the Ohio State Medical Association:

Dr. J. B. Walker, Canton, delegate; Dr. David E. Leavenworth, Canton, alternate; Dr. William A. White Jr., Canton, delegate; Dr. Lloyd L. Dowell, Massillon, alternate; Dr. R. L. Rutledge, Alliance, delegate; Dr. Mark Herbst, Canton, alternate; Dr. John R. Seesholtz, Canton, delegate; Dr. A. E. Boyles, Louisville, alternate. (The latter four being in the midst of terms.)



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relaxes both mind & muscle

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well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

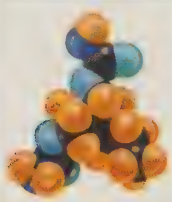
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Two-dimensional treatment of the menopause

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DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

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Dr. Cleon C. Couch, Canton, was elected to the Board of Censors. Present members continuing in office on the Board of Censors include Dr. D. G. Underwood of Navarre, and Dr. G. O. Thompson of Alliance.—*Hartville News and SCMS Bulletin.*

January meeting and program was held in the Belden Hotel, Canton, on the 9th. Speaker was Dr. George A. DeStefano, University Hospital of Cincinnati, whose subject was "Reconstruction of Cranial and Facial Defects with Autogenous Split Rib Grafts."—*Society Bulletin.*

SUMMIT

Dr. Arthur Dobkin, Akron, becomes president of the Summit County Medical Society on New Year's Day.

Others who will be 1958 officers of the oldest medical society in Ohio are: Dr. Donald I. Minnig, president-elect; Dr. William G. Davis, secretary, and Dr. Frank M. McDonald, treasurer.

All four serve on the society's executive council along with Dr. R. G. McCready, immediate past-president; Dr. Carl C. Nohe, editor of the society publication, Dr. E. W. Cauffield, Dr. P. B. deMaine, Dr. Joseph J. Eckert, Dr. Glenn V. Hough, Dr. M. Charles Morgan, Dr. H. Oliver Musser and Dr. Harold E. Muller.—*Akron Beacon-Journal.*

Dr. Charles K. Kirby, assistant professor of surgery, University of Pennsylvania School of Medicine, was the speaker for the January 7 meeting of the Summit County Medical Society in Akron. He spoke on the subject "Recent Advances in Cardiovascular Surgery." Dinner was served at the Akron City Club after which the program was conducted at Akron General Hospital Auditorium.

TRUMBULL

Dr. Aubrey L. Sparks, Cortland, was named president of the Trumbull County Medical Society at the organization's annual Christmas dinner and dance.

Dr. Sparks succeeds Dr. J. A. Browning.

Other officers installed are: Dr. Paul Noonan, president-elect; Dr. Charles Stone, secretary; Drs. Elmer Caskey and Raymond Ralston, delegates to the Ohio Medical Association, and Dr. Sigmund J. Shapiro and Joseph Gledhill, alternates.—*Cortland News.*

A joint meeting of the Medical Society and the Trumbull County Pharmaceutical Association was held on November 20 at Cafe 422 in Warren. Dr. Arthur Tye, head of the Department of Pharmacology, Ohio State University, was the speaker and discussed new drugs placed on the market recently. There were more than 80 members of the two groups in attendance.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

At the business meeting preceding the annual Christmas party of the Belmont County Medical Society December 19 at Belmont Hills Country Club, Dr. David Danenberg of Bridgeport was installed as president for 1958 and Dr. John Brown of Morristown was elected president for 1959.

Dr. Bertha M. Joseph again was elected secretary and Dr. B. C. Diefenbach was named delegate to the state convention. Both reside in Martins Ferry. Dr. Danenberg is the alternate delegate.

Named to the board of censors was Dr. W. L. Davis and Dr. F. P. Sutherland, both of Martins Ferry, and Dr. D. M. Creamer of Bellaire.

The meeting was addressed by Dr. Robert Martin of Zanesville, president of the Ohio State Medical Association.—*Martins Ferry Times.*

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

JACKSON

Dr. Louis J. Jindra, of Oak Hill, was elected president of the Jackson County Medical Society at a meeting of the group held December 11 at Fairgreens Country Club.

Other officers named were Dr. John Cook, Oak Hill, vice-president; and Dr. B. J. Allison, County Health Commissioner, secretary-treasurer.

Dr. C. C. Fitzpatrick, of Jackson, was named delegate to the state convention of the Ohio State Medical Association, and Dr. A. R. Hambrick, of Wellston, was named alternate.—*Jackson Herald.*

SCIOTO

The Scioto County Medical Society met December 9 and named Dr. Sam Meltzer as president for the coming year.

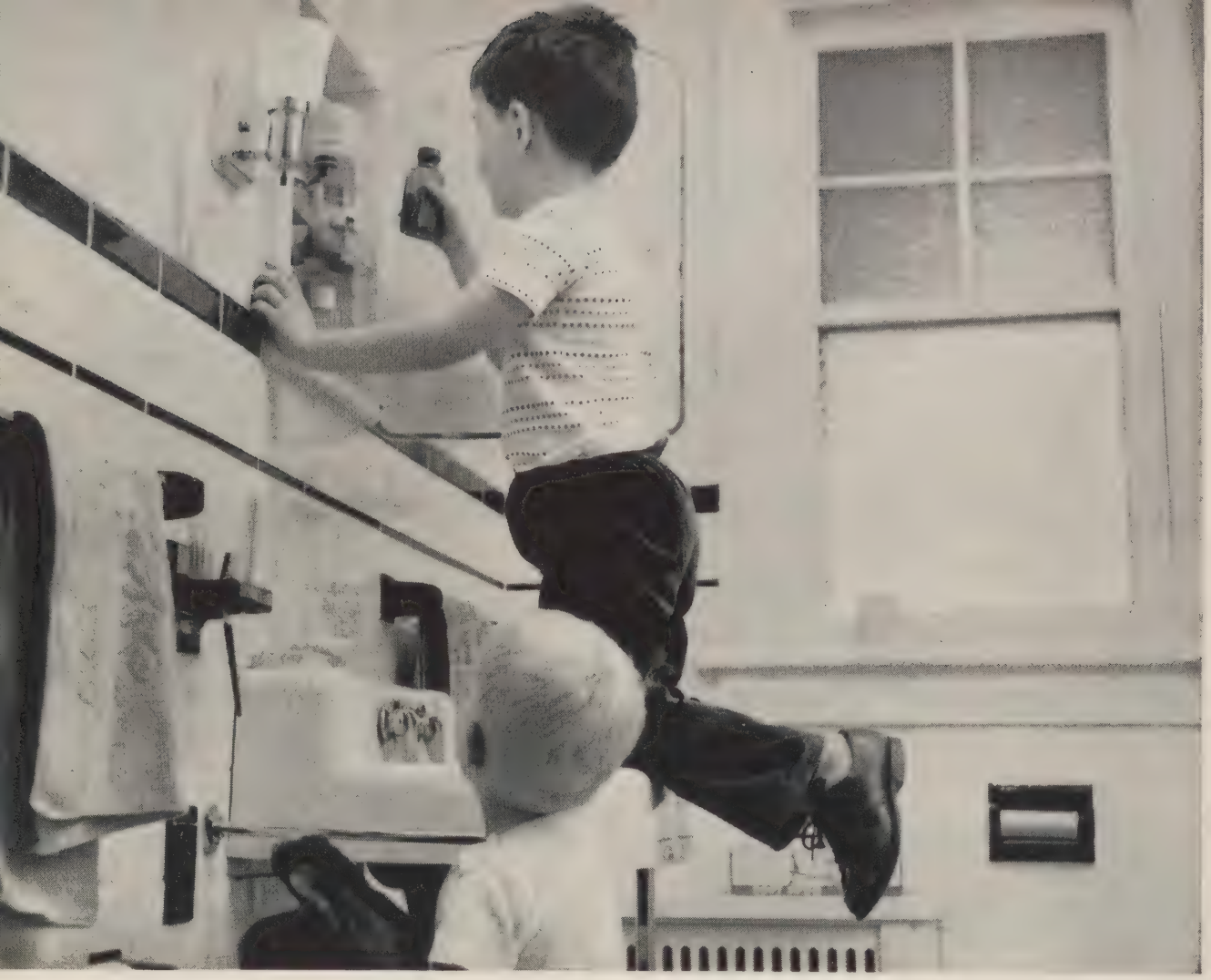
Other officers named were Dr. Louis Chaboudy, vice-president; and Dr. Carl H. Laestar, re-elected secretary-treasurer.

Named to the board of censors was Dr. Joseph T. Gohmann. Dr. Jerome R. Sheets was elected as a legislative committeeman with Dr. Sol Asch being chosen librarian.

Dr. William M. Singleton was named a delegate to the state convention with Dr. Richard L. Wagner as alternate.—*Portsmouth Times.*

The Scioto County Medical Society met at the Nurses Recreation Hall, General Hospital, Ports-

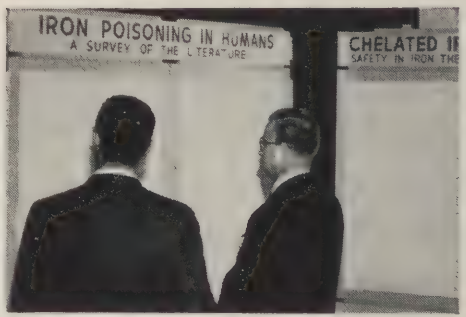
(Continued on Page 242)



JIMMY J.: A CASE HISTORY OF ACCIDENTAL IRON POISONING

Reports of accidental poisoning by oral iron are increasingly common in current literature. However, a recent editorial (South. M. J. 50:117, 1957) can still describe the "shock when it was clearly demonstrated less than a decade ago that iron salts were not without danger to young children, and might even result in their death."

A Scientific Exhibit on "Iron Poisoning"* at the recent A. M. A. Clinical Meeting in Philadelphia points up the immediacy of the problem and sheds new light on the mechanism of iron toxicity. The case history illustrated here is typical of many mentioned in the exhibit. Ferrous sulfate poisoning is quick and often fatal. Even immediate and positive treatment is not always successful.



*Scientific Exhibit on "Iron Poisoning" by W. G. Rohse, Ph.D.; C. R. Kemp, Ph.D.; M. Franklin, M.D., and J. de la Huerga, M.D. at the American Medical Association Clinical Meeting, December 3-6, 1957. Philadelphia, Pa.

This is an advertisement prepared by *Flint* EATON & COMPANY, Decatur, Illinois

Case history pictured here was adapted from recently published report. Bibliographic reference available on request.

The curious, searching quality of a child can be a wondrous thing, wandering continually through a world of new sights and sounds and new objects that need to be experienced. But often the inquiring hand of the child inadvertently finds pain.

This is the case history of Jimmy J., an 18-month-old boy brought to the hospital with a complaint of diarrhea and vomiting. When first seen, Jimmy was in shock. It developed that he had eaten a number of enteric-coated ferrous sulfate tablets about two hours earlier. He vomited ten of the tablets soon after, and vomited again on administration of egg yolk. Now he was weak and somnolent, with hyperactivity of deep reflexes.

Initial laboratory examination showed a hemoglobin of 10.8 grams, RBC 5.4 million, WBC 52,000. *Serum iron level was approximately 55 times higher than normal* — 8150 mcg./100 cc. Necrotic intestinal mucosa was passed per anum.

Forced fluids, antibiotics and dextrose were started, but the patient remained in shock until given 150 cc. of whole blood by scalp-vein transfusion. Subsequent treatment included milk with added electrolytes, vitamin K and levulose. Jaundice developed two days after admission but cleared in five days. Bone marrow was compatible with tissue breakdown or with chronic infection.

Six days after admission, Jimmy was able to take a general diet. Serum iron returned to normal, the patient became asymptomatic eleven days after admission, and was then discharged.

Jimmy was fortunate; approximately one out of every two cases of iron intoxication do not recover.



Jimmy was fed the ferrous sulfate tablets by his older brother. Attractively colored sugar-coated pills have an appeal for young palates, yet may often prove fatal.



On admission to the hospital just two hours later, Jimmy presented the classic triad of iron poisoning—vomiting, shock, leukocytosis. Treatment was started immediately.



Necrotic mucosal tissue passed by rectum indicated local g.i. damage caused by the corrosive action of the tablets. Fluoroscope confirmed presence of tablet material.

CONTINUED



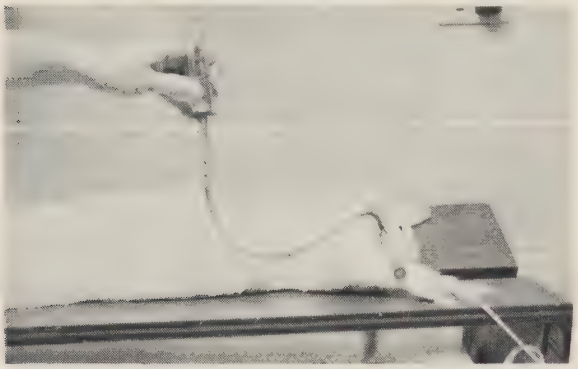
Significantly, serum iron level prior to transfusion had risen to 8150 mcg./100 cc., more than 50 times higher than normal, indicating uncontrolled absorption of iron salts from the child's intestinal tract.



Despite apparent damage to g.i. tissue, Jimmy was able to take food by mouth six days after admission. Thus, systemic toxicity may not be related to tissue damage.

RECENT FINDINGS INDICATE CHELATION MINIMIZES RISK OF IRON TOXICITY

Studies of iron intoxication described in the recent A. M. A. Scientific Exhibit consistently reveal a direct ratio between elevation of serum iron and incidence of fatality. In a series of dogs and rabbits given 250 mg. iron per Kg. as aqueous solutions of ferrous sulfate or gluconate, all animals died. As in the case of Jimmy, toxicity in these experimental animals was always associated with serum iron elevation far beyond total binding capacities. However, in other animals given equal amounts of iron as iron choline citrate (FERROLIP®), an iron chelate, all rabbits and 90 per cent of dogs survived without evidence of toxicity. Thus, *chelated* iron seemed to permit controlled absorption of iron as needed, without decrease in hematinic effect.



Animal studies confirm relationship of fatality to excessive serum iron elevation with ferrous sulfate or gluconate.



A new iron chelate (iron choline citrate—FERROLIP) appears to avoid this excessive elevation of serum iron.

FERROLIP... EFFECTIVE AND SAFE

The inherent safety of FERROLIP is apparently due to chelation. The iron complex—"chelated," or bound—apparently can be absorbed and utilized by the body as physiologically needed, at a controlled rate, thus essentially obviating the possibility of excessive free iron in the blood stream. In contrast to readily dissociable iron salts such as ferrous sulfate or ferrous gluconate, experimental evidence has shown that massive doses of FERROLIP have rarely been associated with a dangerous elevation in serum iron.

FERROLIP has additional practical advantages over other forms of iron therapy. As a chelate, it is nonionized, nonastringent, and it remains in solution at pH levels up to 10.5. Consequently, FERROLIP is essentially free from g.i. irritation; it is not precipitated by protein or phosphate, and it can be given in milk or formula; also FERROLIP does not attack or discolor the teeth.



The Greek word *chele* means a claw. The term *chelation* is now applied to chemical processes whereby metallic ions are sequestered or bound into claw-like rings within certain organic molecules. Chelation can be applied to any problem wherein ions of a metal cause trouble. The iron in FERROLIP is bound by this process.

FERROLIP is available in the following forms:

TABLETS—Three FERROLIP Tablets supply 1.0 Gm. of iron choline citrate equivalent to 120 mg. of elemental iron and 360 mg. of choline base.

SYRUP—One fl.oz. of FERROLIP Syrup provides 120 mg. elemental iron, equivalent of 3 tablets.

DROPS—Each cc. of FERROLIP Drops provides 16 mg. elemental iron and 48 mg. choline base.

DOSAGE: Adults, 1 or 2 tablets or 2 to 4 teaspoonfuls of syrup t.i.d.; children, 1 tablet or 2 teaspoonfuls t.i.d.; 0.5 cc. of drops supplies M.D.R. for infants and children up to 6 years—therapeutic dose as determined by physician.

FERROLIP®

Iron Choline Citrate

a physiologic iron chelate

for RESULTS WITHOUT RISK in iron deficiency anemia

TABLETS	Bottles of 100 and 1000
SYRUP	Pints and gallons
DROPS	30-cc. dropper bottles

also available:

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just 1 tablet t.i.d. (the daily dose) provides:

FERROLIP (Iron Choline Citrate*)	150 mg.
Tricalcium Citrate	600 mg.
Calcium Gluconate	300 mg.
Thiamine Mononitrate	3 mg.
Riboflavin	3 mg.
Niacinamide	30 mg.
Calcium Pantothenate	10 mg.
Pyridoxine Hydrochloride	10 mg.
Ascorbic Acid	200 mg.
Folic Acid	0.5 mg.
Vitamin B_{12} with Intrinsic Factor Concentrate	1 U.S.P. Unit (Oral)
Vitamin A	5000 Units
Vitamin D	500 Units

DOSAGE: 1 tablet t.i.d.

SUPPLIED: Bottles of 60, 100, and 1000.

FERROLIP plus

for macrocytic and microcytic anemias

Each capsule contains:

FERROLIP (Iron Choline Citrate)	200 mg.
Vitamin B_{12} with Intrinsic Factor Concentrate	⅓ U.S.P. Unit (Oral)
Liver, Desiccated, N.F.	100 mg.
Ascorbic Acid	50 mg.
Folic Acid	0.5 mg.
Thiamine Hydrochloride	2 mg.
Riboflavin	1 mg.
Pyridoxine Hydrochloride	0.5 mg.

DOSAGE: 1 capsule t.i.d.

SUPPLIED: Bottles of 60, 100, and 1000. Also available: **FERROLIP plus Liquid,** in 8-fl.oz. and gallon bottles.

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mouth, on January 13 for a program and buffet refreshments. Speaker for the occasion was Dr. Robert Izant, of the OSU Department of Pediatrics and Surgery, Columbus, whose subject was "Abdominal Masses in Children."

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

Following is the incoming president and slate of officers elected by the Lorain County Medical Society for the year: President, Dr. Ben Myers, Elyria; vice-president, Dr. Oscar Schettler, Oberlin; president-elect, Dr. Denis Radefeld, Lorain; secretary-treasurer, Dr. Lawrence Meredith, Elyria; delegates, Dr. Ted Wiseman, Amherst, and Dr. James Stephens, Oberlin; alternates, Dr. John Newman, Avon Lake, and Dr. Henry Kleinhenz, Lorain; member of the Board of Censors for three years, Dr. Lothar Hoffer, Lorain.—L. C. Meredith, M. D., secretary-treasurer.

WAYNE

At the December 11 meeting of the Wayne County Medical Society the following officers were elected: President, Dr. James Robertson; vice-president, Dr. Joel Pratt; secretary-treasurer, Dr. Robert Schulz; delegate, Dr. A. B. Huff; alternate, Dr. A. J. Hartzler; all of Wooster.

A new constitution for the Society was passed, subject to OSMA approval.

Two new members were voted into the Society. They are Dr. Jerry Bosnak, Beeson Clinic, transfer from Cuyahoga County; and Dr. Robert Schulz, Wooster Community Hospital pathologist, transfer from Northampton County (Penna.) Medical Society.

Dr. O. J. Shong, of Rittman, retired in December and is making his home in Florida.—Chas. H. Brant, M. D., 1957 secretary-treasurer.

The chief of the Veterans Administration atomic medicine program in Washington, D. C., announced that doses of radioactive vitamin B-12 are being administered to patients with anemia and stomach disorders and traced to find whether the vitamin is absorbed by the body. The procedure is useful in distinguishing pernicious anemia from other anemia and in planning treatment for patients who have had stomach surgery.

Dr. J. P. Harvey, of Youngstown, has been appointed governor for the State of Ohio in the American College of Cardiology.

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

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PHS Advises Against Community-Wide Tuberculosis X-Ray Campaigns

The U. S. Public Health Service, acting on advice of a committee of medical and public health leaders called in to re-evaluate recent changes in the nature of the tuberculosis problem, is recommending against community-wide chest x-ray campaigns for detection of TB. Instead PHS recommends that communities use tuberculin skin testing as a first step in case-finding, followed up with x-ray examinations for those with positive reactions.

The service suggests, that x-ray examinations be continued on selective groups, those with greatest risk, such as persons confined to hospitals and other institutions, low-income groups, migrant workers and people known to have been exposed to the disease. It was emphasized that groups to be given x-rays should be selected locally, with the choice based on the local tuberculosis problem, the expected yield of new cases and the adequacy of diagnostic and treatment facilities and of follow-up services.

One factor given consideration in reaching the decision, PHS says, is "the problem of low-level radiation exposure from x-rays." To further reduce radiation exposure, both of the operators and the public, PHS urges periodic inspection of all x-ray equipment, and installation of further protective devices where indicated.

Of the new tuberculosis picture, PHS says: "In the last 15 years . . . the tuberculosis problem has changed radically. Some areas of the country are now practically free of active cases of the disease. In other areas, tuberculosis continues to be a serious problem, particularly among certain groups. While the number of active cases has declined almost 30 per cent in the last 5 years, it is estimated that there are still about 250,000 persons with active tuberculosis in the United States today."

The committee that advised PHS to make the recommendations was composed of: Drs. Russell H. Morgan, chief radiologist, Johns Hopkins University Hospital, and special consultant to the surgeon general on the public health aspects of radiation; Ralph Dwork, director, Ohio State Department of Health; Floyd Feldman, medical director, National Tuberculosis Association; Joseph Stocklen, tuberculosis control officer, Cleveland and Cuyahoga County Health Department.

Dr. Richard L. Fulton, is the new president of the Metropolitan Health Council of the Columbus area. He succeeded Dr. James Hughes.

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SURGERY—Surgical Technic, two weeks, Mar. 24, Apr. 21, May 12. Surgery of Colon and Rectum, one week, Apr. 7. Basic Principles in General Surgery, two weeks, Apr. 7. Treatment of Varicose Veins, Apr. 7, May 5. Gallbladder Surgery, three days, Mar. 31. Surgery of Hernia, three days, Apr. 3. General Surgery, two weeks, May 5; one week, May 12. Fractures & Traumatic Surgery, two weeks, Mar. 17. Breast & Thyroid Surgery, one week, May 5.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Mar. 17. Vaginal Approach to Pelvic Surgery, one week, Apr. 28. General & Surgical Obstetrics, two weeks, Mar. 31.

MEDICINE—General Review Course, two weeks, May 12. Electrocardiography & Heart Disease, two weeks, Mar. 17. Hematology, one week, June 2. Gastroenterology, two weeks, Apr. 14.

PEDIATRICS—Two-Week Intensive Course, Apr. 21.

DERMATOLOGY—Clinical & Didactic Course, two weeks, May 5.

RADIOLOGY—Diagnostic X-Ray, two weeks, Apr. 28. Clinical Uses of Radioisotopes, two weeks, May 5.

UROLOGY—Two-Week Intensive Course, Apr. 14. Cystoscopy, Ten-Day Practical Course, by appointment.

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The Sexes and Death . . .

Women's Longevity over Men Continues To Expand: Accidents Claim More Lives than Does Any Single Fatal Disease. Survey Over the Years Shows

WOMEN'S longevity over men results from the more rapid decline in their mortality since 1900, rather than any increase in the death rate among men, according to the Health Information Foundation.

A Foundation survey shows the 1956 life expectancy of females at birth was six years more than men, a widening of the slightly higher longevity they had over men in 1900.

In 1956, according to the National Office of Vital Statistics, there were in the United States 228,000 more male than female deaths. Excess male mortality is characteristic of nearly all leading diseases; but the widening differential has, to a considerable extent, been associated with a shift in the leading causes of death from communicable diseases at the turn of the century to the degenerative diseases today.

Patterns Change

In 1900 pneumonia and influenza, tuberculosis, and diarrhea and enteritis—three of the five leading causes of death, accounting for nearly a third of total deaths—resulted in a slight excess male mortality. While the importance of these diseases declined considerably by 1955, the excess male mortality rose sharply.

Heart disease in 1900 caused an excess male mortality of only 11 per cent, but in 1955 the differential in that disease climbed to 78 per cent. This single disease accounts considerably for today's excess male mortality rate.

The result has been that women outnumber men at all ages past the mid-twenties. Among persons aged 65 and over, the excess is more than a million and, if current trends continue, is expected to increase to 3½ million by 1975. Even at midlife—45-64—women will outnumber men by 2.2 million, or 11 per cent, the Foundation reports.

Research currently is seeking to learn if the sex differential in mortality is due to biological or social (including environmental) factors.

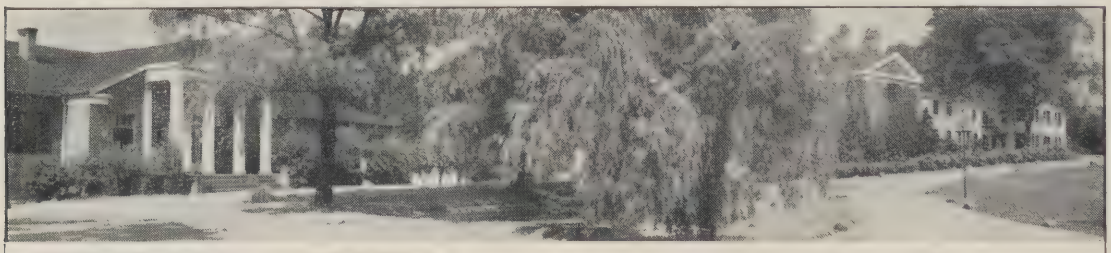
The Biggest Killer

By far the highest excess of male deaths among the leading causes, especially in the younger ages, occurs among accidents. This cause alone accounts for over four-fifths of the male toll from all causes of death at ages 10-24, and nearly three-fourths at 25-34.

Another changed picture is that of cancer. In 1900, malignant neoplasms caused about four per cent of all deaths, females exceeding males by 65 per cent. By 1955 cancer accounted for 16 per cent of all deaths, male mortality exceeding female by 20 per cent, increasing to 50 per cent in the 60-74 age group.

The only major disease having a higher age-adjusted mortality rate for women and men, the Foundation reported, is diabetes mellitus—35 per cent higher.

But statistics show that the five leading causes of death—heart disease, cancer, vascular lesions affecting the central nervous system, accidents and pneumonia and influenza—inflict more mortality on men than women.



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it could be mild
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assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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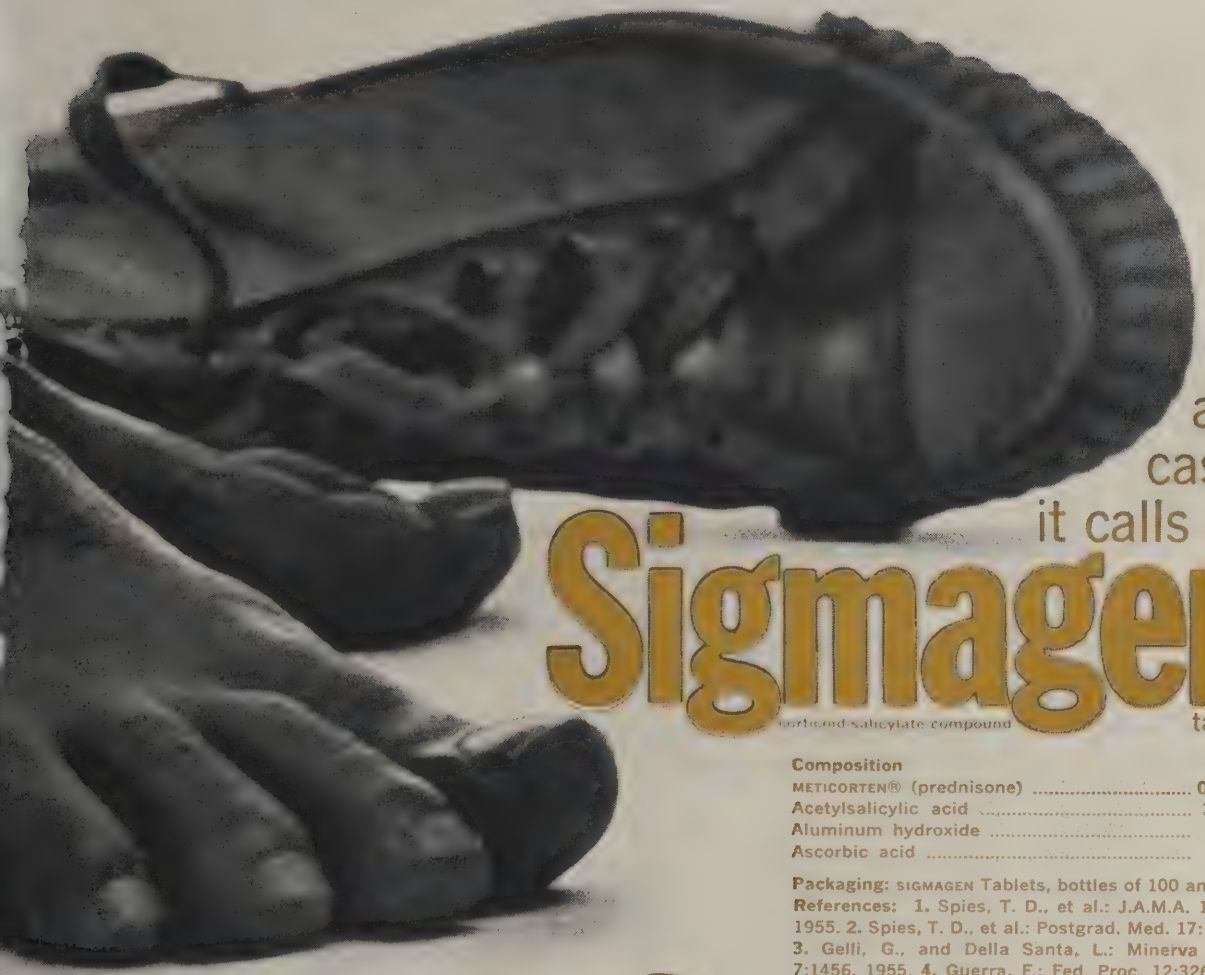
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

SQ-J-618

Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. C. H. Bell, 754 Dickson Parkway, Mansfield
(See Page 137 for roster of officers.)

BUTLER COUNTY

Attending the First District meeting of the Woman's Auxiliaries of County Medical Societies at the Sinton Hotel, Cincinnati, were Mrs. Clifford Fening and Mrs. Gilbert Wagoner. Mrs. Herbert Warm of Hamilton, past-president of Butler County Auxiliary is the District Director. Members of the Hamilton County Auxiliary were hostesses for this meeting.

A joint social meeting of the Auxiliary and the Butler County Medical Society was held on November 21 at the Sports Bowl. Thirty-three physicians and their wives enjoyed the get-together which included dinner followed by an evening of bowling. The committee in charge of arrangements were Mrs. Robert Tennant, Mrs. David Gerber and Mrs. Anthony Kokenakis.

CLARK COUNTY

The Christmas Card Fund of the Woman's Auxiliary to the Clark County Medical Society received a boost at the auxiliary dance on December 7. "Just an Old Fashioned Christmas" was the theme used for members and their husbands for the affair held at the Springfield Country Club.

A feature of the evening was the annual collection of the "Christmas Card fund." For the third consecutive year, members who wished to participate in the program used this occasion to wish each other "Merry Christmas" and make a contribution to a philanthropy fund in place of exchanging Christmas cards. The fund has made possible a variety of benefactions to such causes and groups as the Clark County Children's Home, the County Home for the Aged, the Clark County Sanatorium, the Cerebral Palsy Clinic, Town and Country Day School, Community Welfare Council, Student Nurses, Safety and Rehabilitation pamphlets and health education films for use in the schools and the American Medical Education Foundation.

Mrs. D. H. Guyton and Mrs. E. W. Schilke served on the Hospitality Committee as chairmen with Mrs. A. T. Anton and Mrs. H. E. Sanders assisting. Mrs. C. T. Doeing did the poster work. The philanthropy fund is under the chairmanship of Mrs. Paul W. Schanher, Jr.

COLUMBIANA COUNTY

The Woman's Auxiliary to the Columbiana County Medical Society met at the East Liverpool Country Club with thirty-two members and one guest present. Hostesses were Mrs. R. C. Costello, Mrs. J. A. Fraser and Mrs. C. H. Bailey of East Liverpool.

Mrs. Virgil Hart, president, presided at the business meeting. In accordance with the Student Nurse Recruitment Program, a candidate from the northern portion of the county was selected to receive the 1958 scholarship.

The legislative chairman discussed the Jenkins-Keogh bill and the members voted to give the Medical Association active assistance in support of this legislation. A Christmas Seal Bond was purchased.

Auxiliary members in each locality in this county will distribute Personal Health Information cards to the public. These cards were prepared by the American Medical Association as part of their National Public Safety Program. Mrs. C. J. Lehwald is chairman of this project. Red Cross officials will be assisted in the Bloodmobile work.

Mrs. Robert Popejoy of East Liverpool demonstrated many novel and interesting methods of wrapping gifts for Christmas and other occasions.

CUYAHOGA COUNTY

A major activity on Auxiliary's agenda each year is Nurse Recruitment. In conjunction with the Council and League for Nursing, the Auxiliary has sponsored Future Nurse Clubs throughout the county in the hope of filling the ever increasing demand for nurses and other hospital personnel. A total of 550 Future Nurses rallied in the Academy Auditorium for a discussion and tour. Silver trays are awarded each year to the school with the greatest number of participating students. The trays are inscribed as being presented by the Academy of Medicine of Cleveland and its Auxiliary.

The Chrysanthemum Ball was successful beyond all expectation. Hotel Statler Ballroom with a seating capacity of 480 opened its entire balcony to accommodate a record crowd of 575 Academy of Medicine doctors and their Auxiliary wives. Mrs. Roscoe J. Kennedy, Auxilary president, was presented a sheaf of red roses by Dr. Thomas Kinney, Academy president, for her outstanding executive achievements.

The Junior Chamber of Commerce of Cleveland awarded Mrs. Christopher Colombi, along with five other outstanding members of the community, an award for her work on the polio drive of last year. It was said that Cleveland's extensive vaccination program led the nation, and that the

(Continued on Page 252)

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A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; pathology, radiology, anatomy, operative proctology on the cadaver, anesthesiology, witnessing of operations, examination of patients preoperatively and postoperatively in the wards and clinics; attendance at departmental and general conferences.

UROLOGY

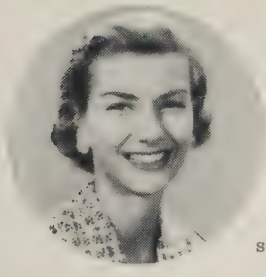
A combined full time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the Ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical medicine; continuous instruction in cystoendoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as prostatic resection.

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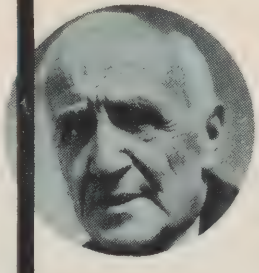
to relieve . . . and thereafter **prevent** . . . fecal dehydration in:

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Molybdenum	0.5 mg.	Iodine	0.15 mg.
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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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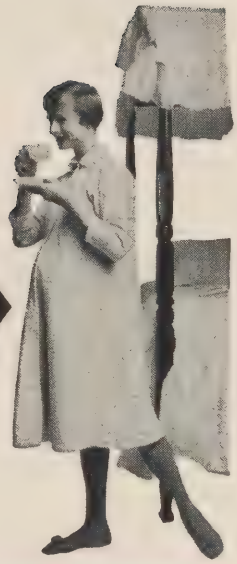
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References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

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phosphate-free calcium, 10 essential vitamins, 8 important minerals. Bottles of 100.

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job Auxiliary performed was truly monumental. This comment was from Dr. Hiscock, immediate past-president of the American Public Health Association, whose 7000 delegates were meeting in Cleveland at the time.

ERIE COUNTY

The Woman's Auxiliary met at the Business Women's Club for luncheon, a November business session and program. Dr. Florence McCullough, North Central district director of the Ohio Congress of Parents and Teachers, was guest speaker.

Important reports were made during the business meeting which followed the program. Public Relations chairman, Mrs. C. R. Swanbeck announced that the family health records have been placed in the obstetrical department of both hospitals and with the Erie County public health nurses. The health wallet cards are being placed in doctors' offices, and distributed to organizations upon request.

An important function on the Auxiliary agenda was the annual Christmas teas for the personnel of Providence and Good Samaritan Hospitals held on December 12.

FAIRFIELD COUNTY

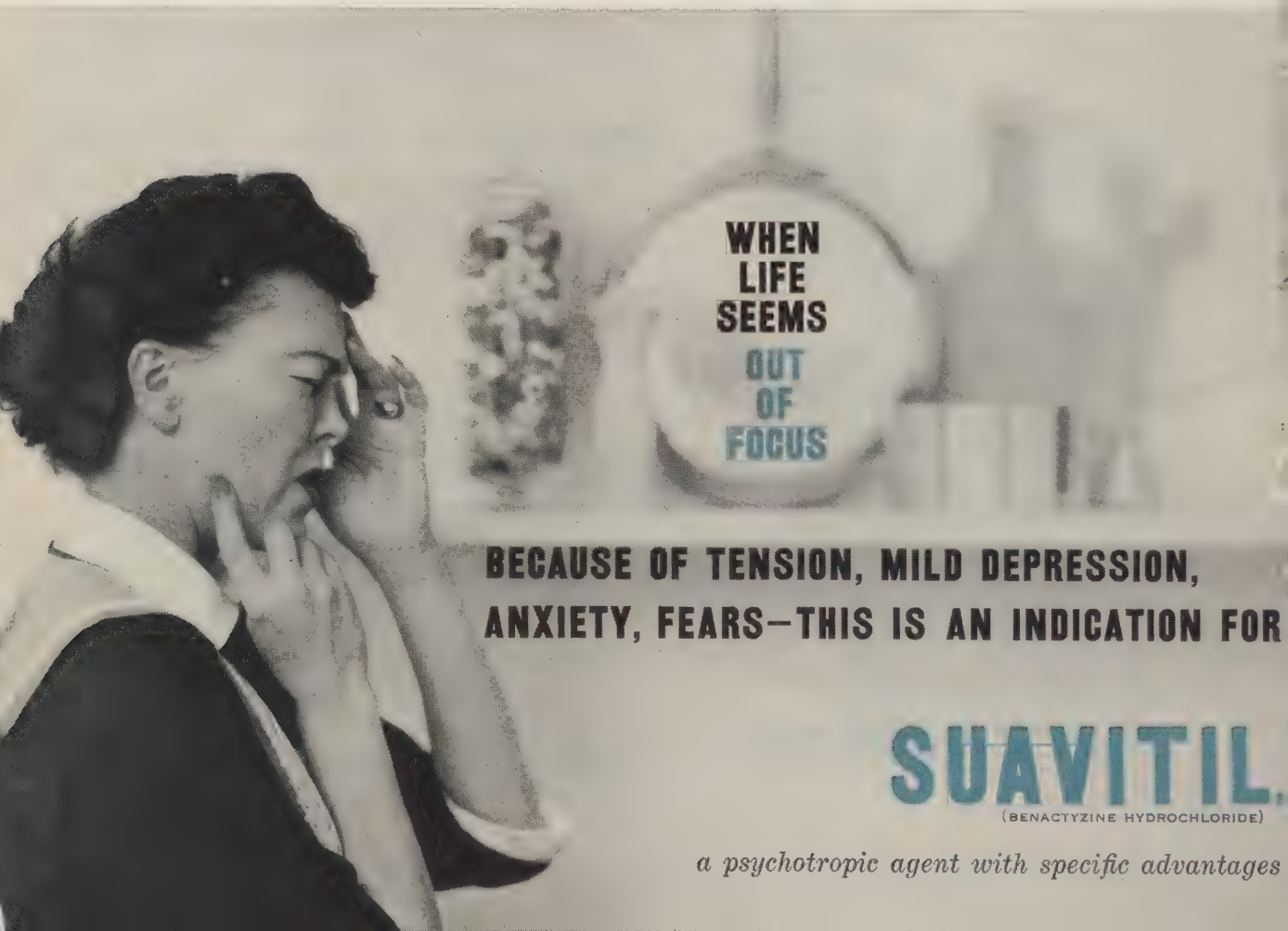
The Auxiliary to the Fairfield County Medical Society held its annual Christmas party at the Lancaster Country Club on December 12. Place cards in the form of a doctor's prescription directed the 68 guests to the dining table.

Mrs. George LeSar, president, introduced Mrs. Stephen Hodsden, social chairman. Mrs. Hodsden surprised Dr. and Mrs. Clifford Snider with the announcement that the entire program was in their honor, and the couple was presented matching luggage from the Auxiliary. Dr. Fred Spangler presented Dr. Snider with a Hamilton electric wrist watch from the Medical Society. Assisting Mrs. Hodsden were Mrs. Stanley Sneeringer, Mrs. George Mogil and Mrs. Harold Schwendeman.

On December 16 Auxiliary members met for coffee at the new home of Mrs. George F. Jones. Each member brought homemade cookies. These were sold and the profit will be donated to the American Medical Education Foundation. Mrs. Jones, Mrs. Charles Clark and Mrs. George LeSar were hostesses.

HAMILTON COUNTY

The yearly dinner dance of the Woman's Auxiliary to the Hamilton County Medical Society



was held on December 7 in a holiday setting at the Hotel Sheraton Gibson Roof Garden. More than 400 persons attended the colorful affair, which is the principal feature of the Auxiliary's social calendar.

Given for the benefit of the organization's philanthropic fund, the dance proceeds have provided both medical and nursing scholarships and annual gifts to Longview State Hospital and the Hillcrest School. Mrs. Milton W. Gwinner and Mrs. James S. Mills were the co-chairman of the party this year.

KNOX COUNTY

The auxiliary to the Knox County Medical Society met in the home of Mrs. Thomas Bogardus, Jr., on November 21. At the business hour, in charge of Mrs. C. E. Cassaday, the members planned to serve at the meeting of the Golden Age Club in January; voted to buy an audiometer for use in the county schools, and discussed plans for a nursing recruit tea for February.

Refreshments were served. Mrs. Henry Lapp and Mrs. James McLarnan were co-hostesses. Later the group toured the museum of James Beam on Newark Rd. with Mrs. Beam giving the history of many of the articles.

LOGAN COUNTY

Members of the Auxiliary to the Logan County Medical Society met for the November meeting in the home of Mrs. C. H. Thompson in West Mansfield for a "Gourmet Party" cover dish. After the luncheon the recipes were sold making a nice sum of money for the treasury. Mrs. George Freetage president conducted a business meeting. It was voted to continue giving *Todays Health* to all the schools.

LORAIN COUNTY

The Auxiliary was hostess when the Eleventh District Meeting of the Ohio State Medical Auxiliary was held on November 14 at the Elyria Country Club. Registration preceeded luncheon.

Mrs. Franz Gruen, director of the District, introduced Mrs. W. R. Gibson president-elect and Mrs. Van Epps, second vice-president of the Ohio State Medical Auxiliary. Mr. H. A. Zealley, superintendent of Elyria Memorial Hospital, was the guest speaker for the afternoon and introduced by Mrs. Gruen.

Mrs. W. R. Gibson reviewed an important

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point from the State Presidents' and Vice-Presidents' meeting by stating that in our unity in purpose and friendship, doctors' wives are powerful allies for their husbands in creating good public relations.

A letter from Mrs. V. R. Frederick, president of the State Auxiliary, called attention to the items to be emphasized in every county auxiliary during 1957-58.

Mrs. Van Epps explained the National Theme and discussed organization and membership in the Eleventh District. Mrs. Gruen asked presidents of the county auxiliaries to relate important phases of their programs for the year.

MIAMI COUNTY

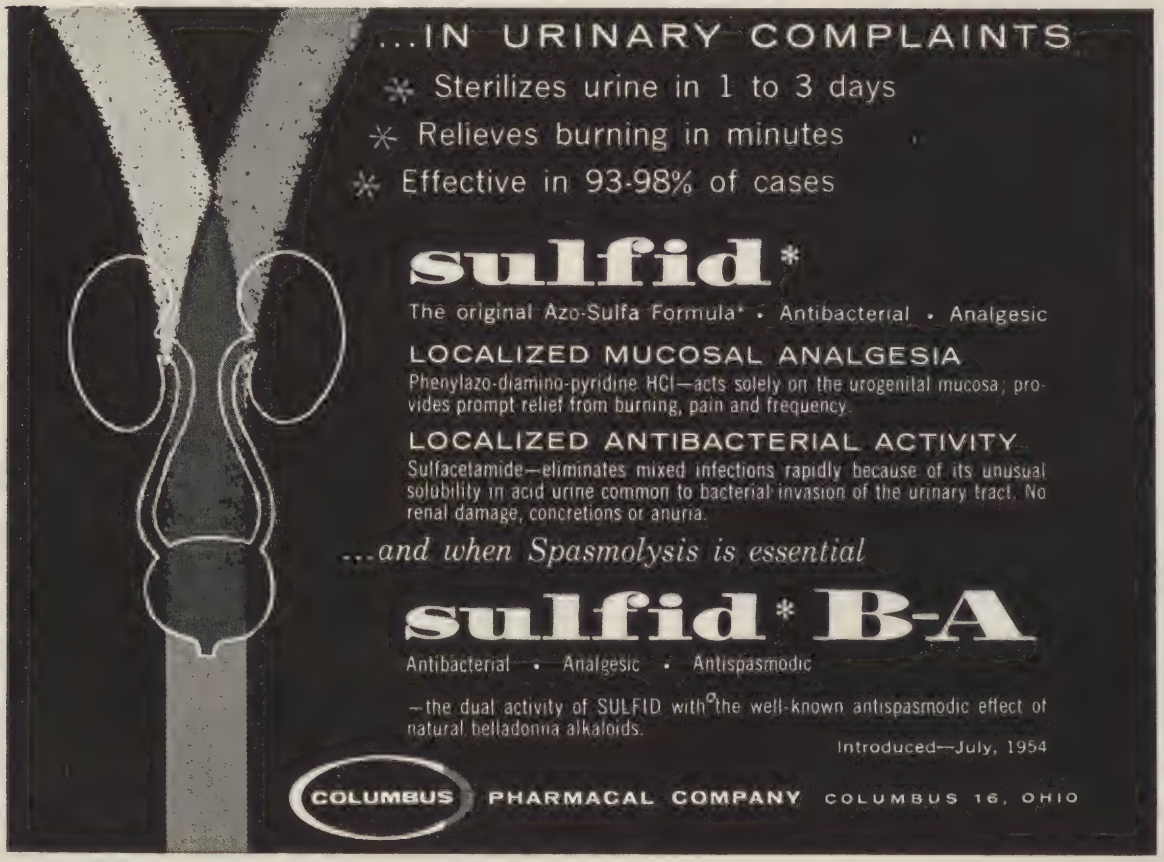
Since 1952, the Auxiliary to the Miami County Medical Society has held an annual tea to better acquaint interested high school juniors with nursing as a career. For the first time this year a breakfast was held instead. This will be followed up in the spring by a scholarship test, which is offered to any Miami County high school senior interested in nursing. From these applicants, one is chosen for a three year scholarship to the school of her choice. Student nurses who are now attending school through these scholarships are the Misses Judith Landrey of Troy, Susan Frances of Tipp City, Janet Stephan of Piqua and Barbara Hoban of Piqua. Miss Stephan and Miss Hoban sat on the panel when Mrs. Elva Evans, executive secretary for the Ohio Council and League of Nursing, spoke to the group on "Careers in Nursing." An informal discussion and question and answer period followed her talk.

RICHLAND COUNTY

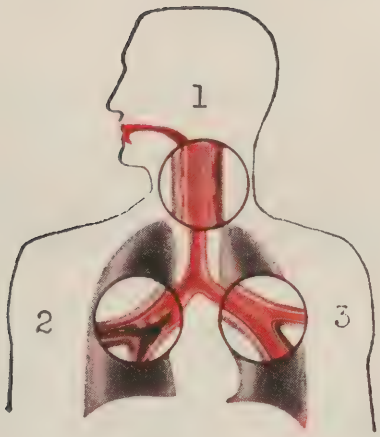
"Silent" Auction of commodities ranging from Christmas decorations and gifts to homemade bread featured the December 2 luncheon meeting of the Woman's Auxiliary to the Richland County Medical Society. Proceeds of the sale will be divided between the American Medical Education Foundation and the Nurse Recruitment Fund, the two outstanding projects of the group this year.

Members of the Mansfield Future Nurses Club are now in the midst of selling cashew nuts, one of their projects for the year, to finance field trips to hospitals. Members of the auxiliary, sponsors of the club are in charge of the project. A panel meeting was recently held when members of the Future Nurses club and prospective nurses met for a nurse recruitment program. Local nurses projected the advantages of a three year hospital training program, while Mrs. Helen Mickak, pub-

(Continued on Page 256)



breaks up cough*



* Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). **C I B A**

lic relations director for nursing at City Hospital, Cleveland, and two representatives from Ohio State University cited reasons as to why they selected the longer degree type of training.

ROSS COUNTY

Mrs. H. M. Crumley spoke on the Health Career Club at a dinner meeting of the Woman's Auxiliary to the Ross County Medical Society at the Lynne House. The club was organized at Chillicothe High School for girls interested in nursing and other careers in the health field.

Mrs. Robert Swank presided at the auxiliary meeting and introduced Mrs. Robert Giesler, radio and visual education chairman, who spoke on the new series of programs on health. Mrs. John Franklin conducted the Hospital Guild 1 meeting and introduced Mrs. Claude Gray and Mrs. William Gray who reported on Hospital Guild 10 projects. Mrs. Franklin urged all members to give hours to the Hospital Snack Shop.

SCIOTO COUNTY

A demonstration of his photographic invention by Dr. Wells McCann of Wheelersburg was a highlight of the afternoon when the Woman's Auxiliary to the Scioto County Medical Society met in the home of Mrs. W. E. Daehler.

During a short business meeting conducted by Mrs. William Hugenberg, president, Mrs. B. U. Howland gave a report on the 9th District meeting held at Lake White. Mrs. Howard Baughman Jr. urged members to renew magazine subscriptions and Mrs. A. P. Hunt gave a report on legislation. A report on the telephone bridge, proceeds of which go to the American Medical Education Foundation and the nurse's fund, was made by Mrs. Robert Counts, chairman of the ways and means committee. On December 11, an auction and baked goods sale was held in the home of Mrs. Clyde Fitch.

STARK COUNTY

Eighty-five members of the Woman's Auxiliary to the Stark County Medical Society were guests at a holiday tea on December 17 and contributed Christmas gift packages for under-privileged children. Mrs. Amelia Gang, executive director of the Visiting Nurse Society of Canton distributed the gifts and was a guest of the auxiliary which was entertained by Mrs. Howard Weaver. Mrs. Richard G. Spitzer, president, Mrs. R. K. Ramsayer, president-elect, Mrs. Herbert A. Jones and Mrs. L. H. Werley presided at the tea table. Mrs. Sidney Larson was chairman with Mrs. James Bahrenburg, co-chairman.

SUMMIT COUNTY

The Woman's Auxiliary to the Summit County Medical Society met for a dessert and coffee on December 3 in the Eva P. Craig Auditorium at Akron General Hospital. Mr. Jack Richards, director of the Falls Art Center spoke on the "Trail of Job." The wives of the interns and residents of the Akron Hospitals were the Auxiliary's guests.

Mrs. Robert Hemphill, chairman of AMEF sold chances for the floral table decoration and the profits went to AMEF.

At the present the Auxiliary is underwriting the cost of two courses of "Milestones for Marriage" for high school seniors in Akron. This is a series of letters published by the Louisiana Association of Mental Health and is used as a part of the regular curriculum. Mrs. R. B. Smith, Mental Health Chairman, reported that school authorities are quite pleased and are considering this as a pilot study for future plans.

The Safety Committee headed by Mrs. M. A. Gallagher has been working hard distributing Health Wallet Cards and Immunization Records Books through the Akron and Summit County Schools.

Health Days will be held March 7-8 and 10 in the Auditorium at O'Neil's Department Store in Akron.

Members of the auxiliary volunteered to fill the

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requests of 75 patients who were in hospitals and wanted to vote.

The "Oldsters" as an outgrowth of the auxiliary Hobby Show are establishing a year-round center for recreation, workshop, display and sales. The Oldsters have given themselves a name—Senior Citizens. They requested and needed help and the Auxiliary voted to accept this responsibility as an extension of the Hobby Show project. The following members have been appointed as the Auxiliary's representatives to the Board of Trustees: Mrs. D. L. Gordon, Mrs. E. L. Voke, Mrs. Arthur Dobkin, Mrs. E. L. Mollin and Mrs. R. R. Plisikin.

TRUMBULL COUNTY

The Trumbull County Medical Auxiliary held its monthly meeting on November 21 with Mrs. Clyde Muter, president, presiding. Special guests for the day included Mayor William C. Burbank; members of the Trumbull County Bar Association Auxiliary; members of the Corydon Palmer Dental Society Auxiliary and the student nurses from Trumbull Memorial Hospital. The special feature of the program was guest speaker, Miss Carol Lane, woman's travel editor for Shell Oil Company.

Huron Road Hospital Will Present Seminar on Endocrinology

The medical staff of Huron Road Hospital, Terrace and Belmore Roads, Cleveland, is sponsoring a two-day postgraduate seminar on Tuesday and Wednesday, February 25 and 26, where distinguished guest speakers as well as Cleveland Area physicians will present material covering most of the recent developments in the field of Endocrinology and Metabolism.

The program begins at 9:00 a. m. on Tuesday. Fee, which includes two luncheons, is $15.00 except for interns or residents who may attend without charge. A copy of the program and other details may be obtained by writing Staff Office, Huron Road Hospital, 13951 Terrace Road, Cleveland 12, Ohio.

The 36th annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 24-29 at the Bellevue Stratford Hotel, Philadelphia, Pa. Details may be obtained by writing to the organization's headquarters, 30 N. Michigan Ave., Chicago 2.

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American Medical Association, Annual Session, San Francisco, June 23-27.

American College of Surgeons, Sectional Meeting, New York City, March 3-6.

American College of Surgeons, Course in Fractures and Other Trauma, Chicago, April 16-19.

Amercan Trudeau Society, 53rd Annual Meeting, Philadelphia, Pa., May 19-22; concurrent with meetings of the National Tuberculosis Association.

Frank E. Bunts Educational Institute, Cleveland Clinic, Course for General Practitioners, February 12-13.

Fifth International Congress of Internal Medicine, Philadelphia, Pa., April 24-26.

Northern Tri-State Medical Association, Annual Meeting, May 8, South Bend, Ind.

Ohio Academy of History of Medicine, Taft Museum, Cincinnati, April 26.

Ohio State Heart Association, 1958 Annual Meeting, April 14, Cincinnati.

Pan American Medical Women's Alliance, Sixth Biennial Congress, Hotel McAllister, Miami, Fla., April 14-17.

Symposium on Neurological Problems for General Physicians, Netherland - Hilton Hotel, Cincinnati, February 23.

Veterans Administration Clinical Conferences, Weekly on Wednesdays, 8:00 to 9:00 a. m., Cuyahoga Bldg., Cleveland.

West Virginia State Medical Association, Annual Meeting, White Sulphur Springs, W. Va., August 21-23.

Dr. Charles E. Raven, personal chaplain to Queen Elizabeth of England and recent vice-chancellor of Cambridge University, has accepted an appointment as the University of Cincinnati College of Medicine's first visiting professor of the philosophy of science. The British scientist, theologian, and scholar will arrive in Cincinnati in March. He will present a series of public lectures on the contributions of medicine to the philosophy of science.

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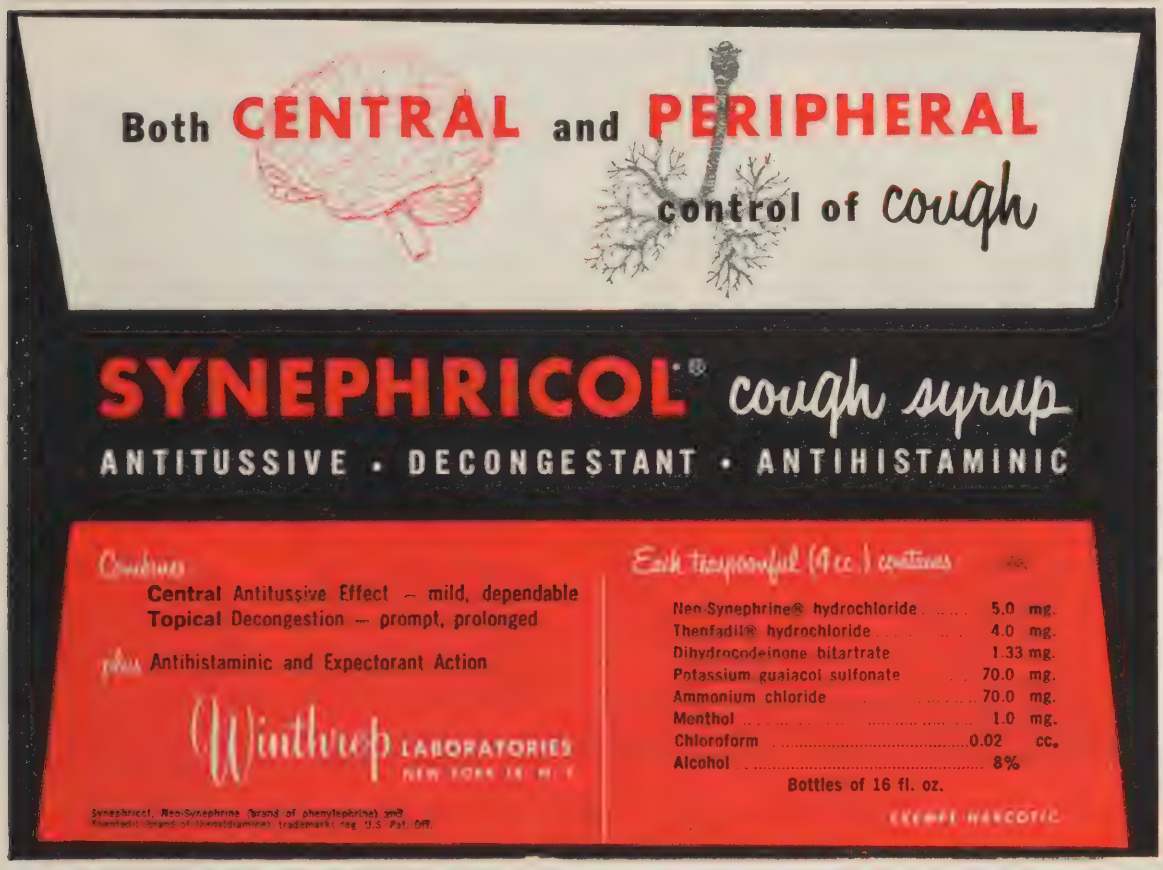
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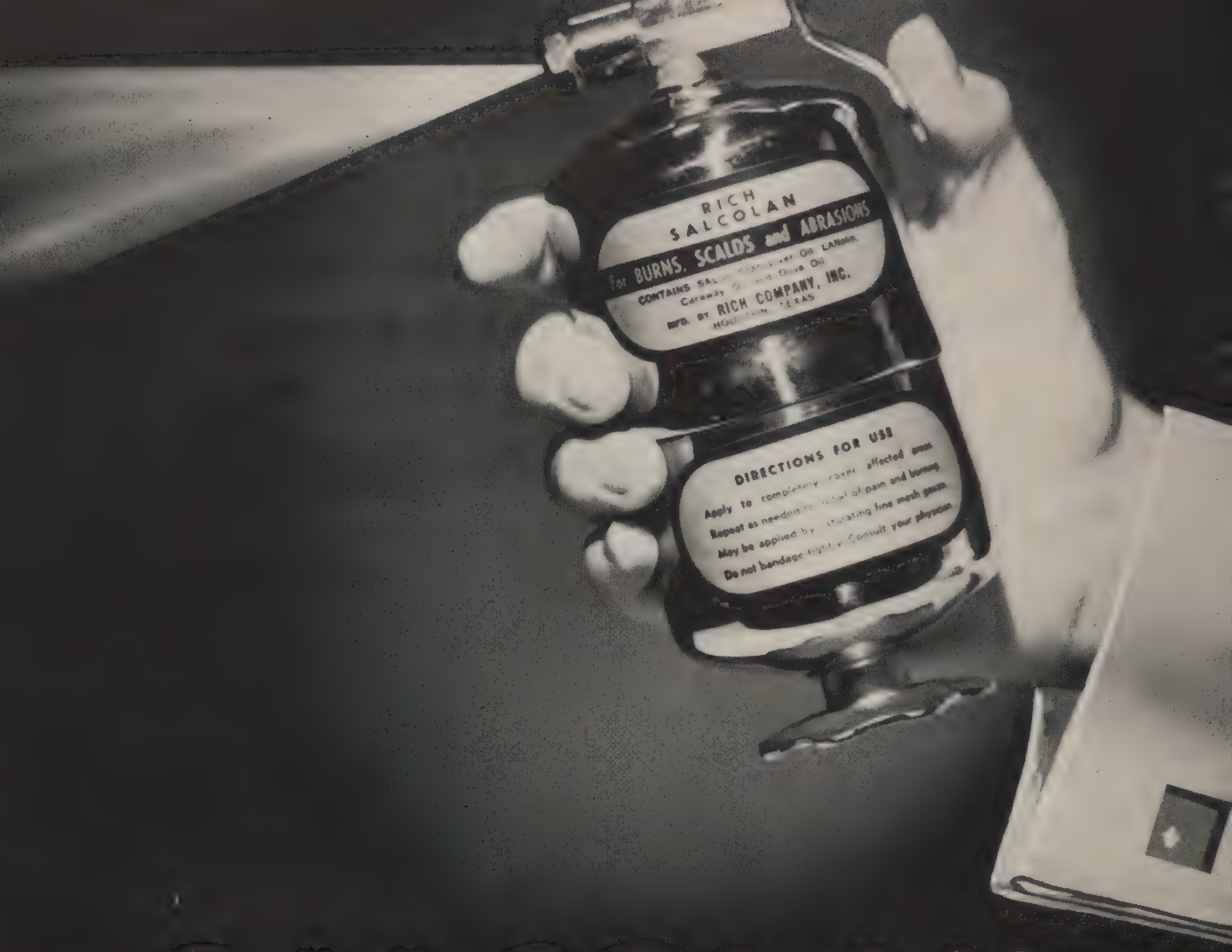
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1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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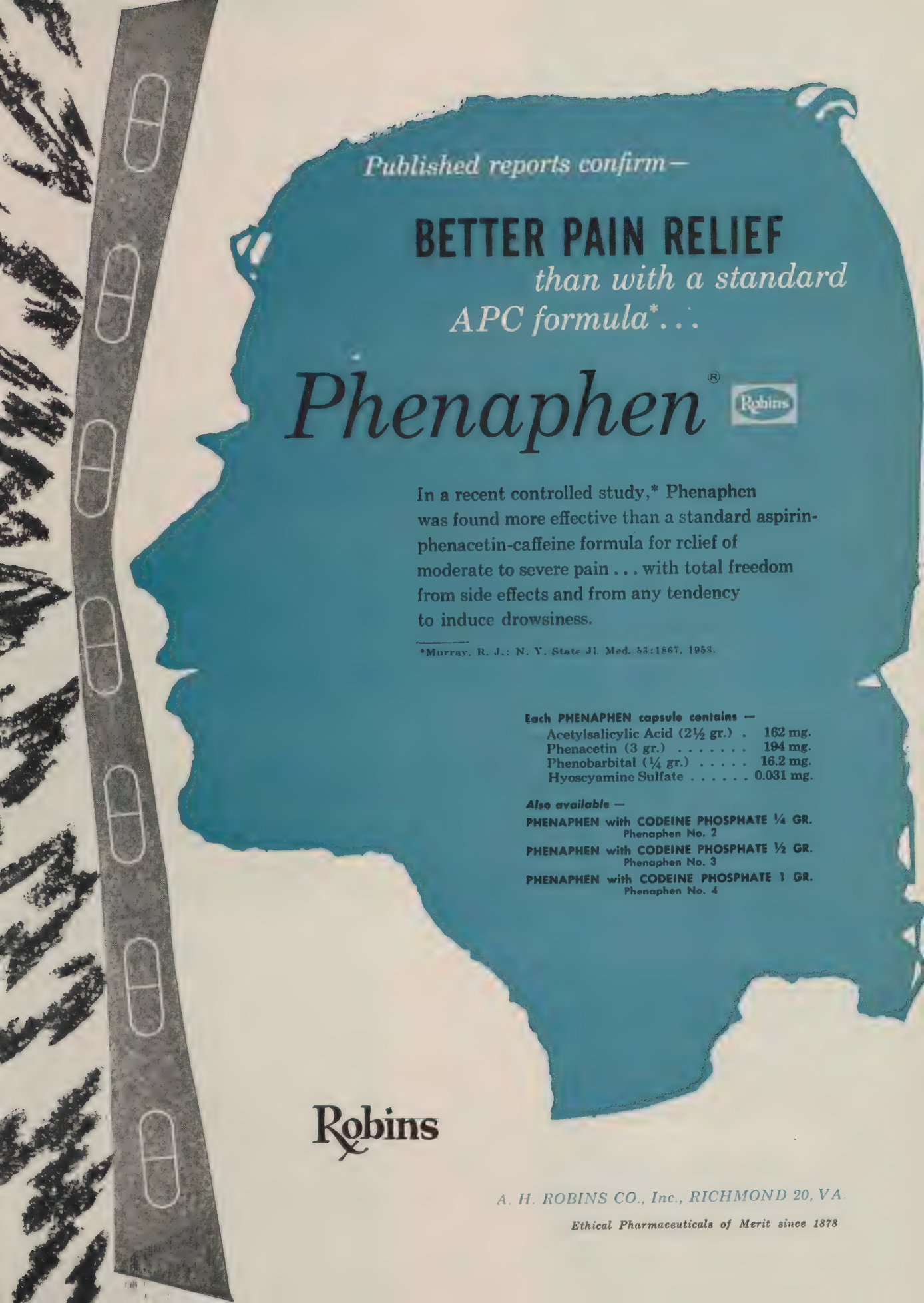
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*Murray, R. J.: N. Y. State Jl. Med. 58:1867, 1958.

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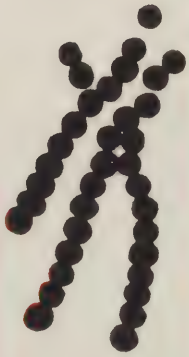
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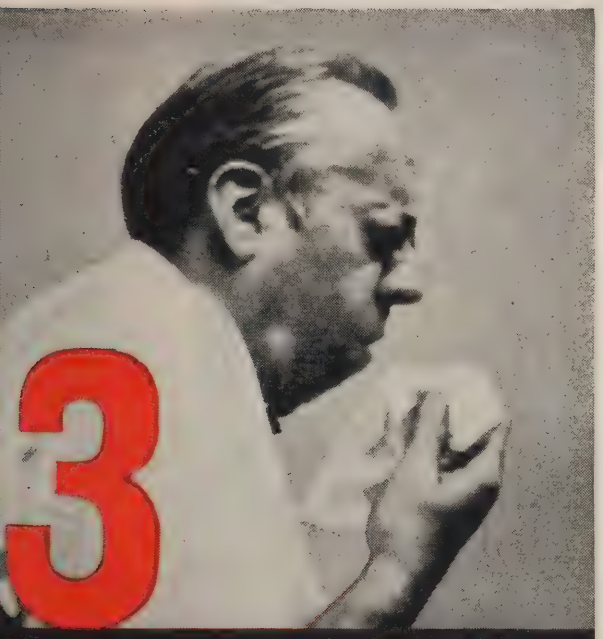
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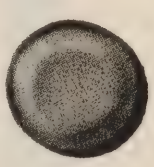
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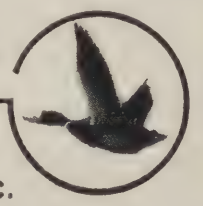
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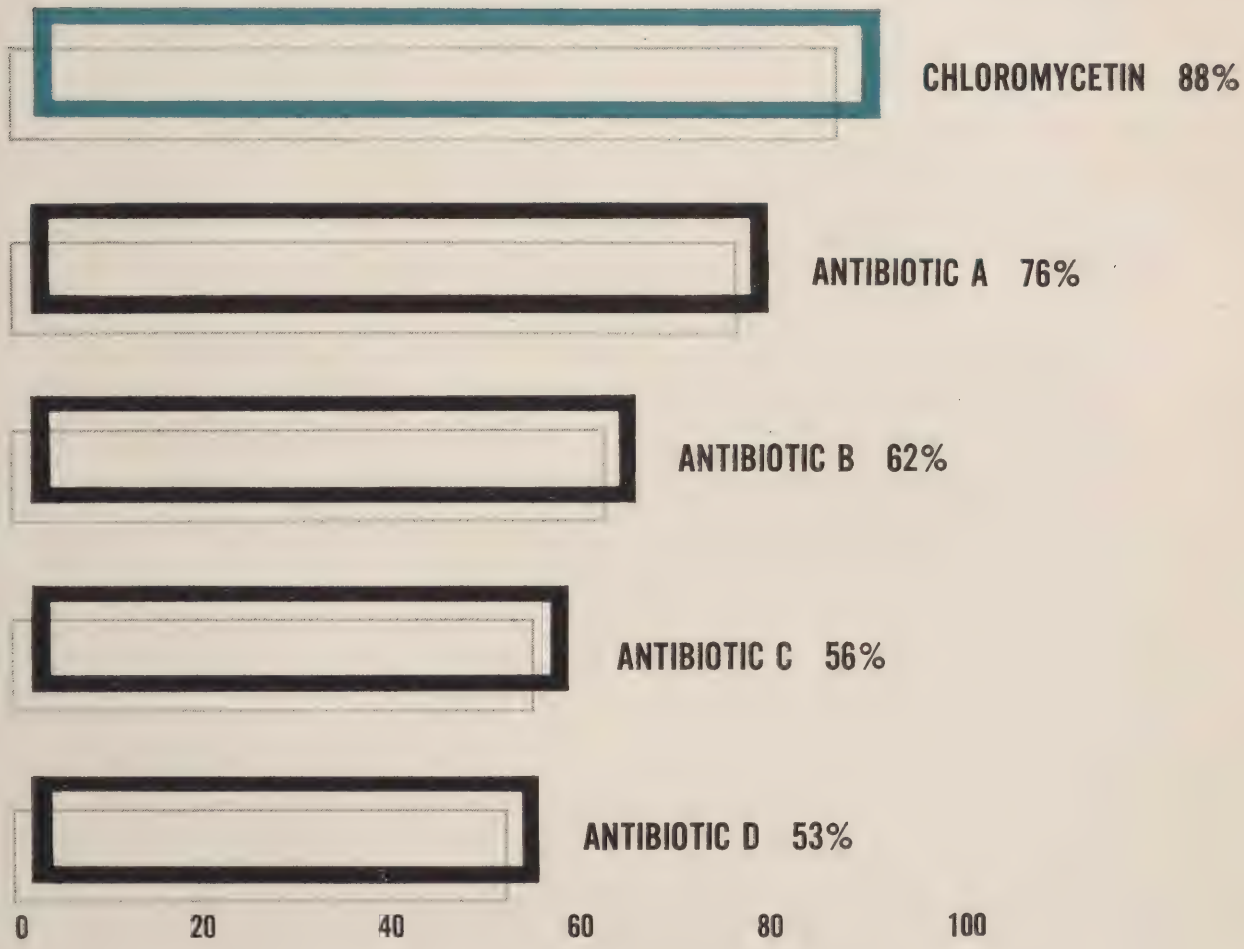
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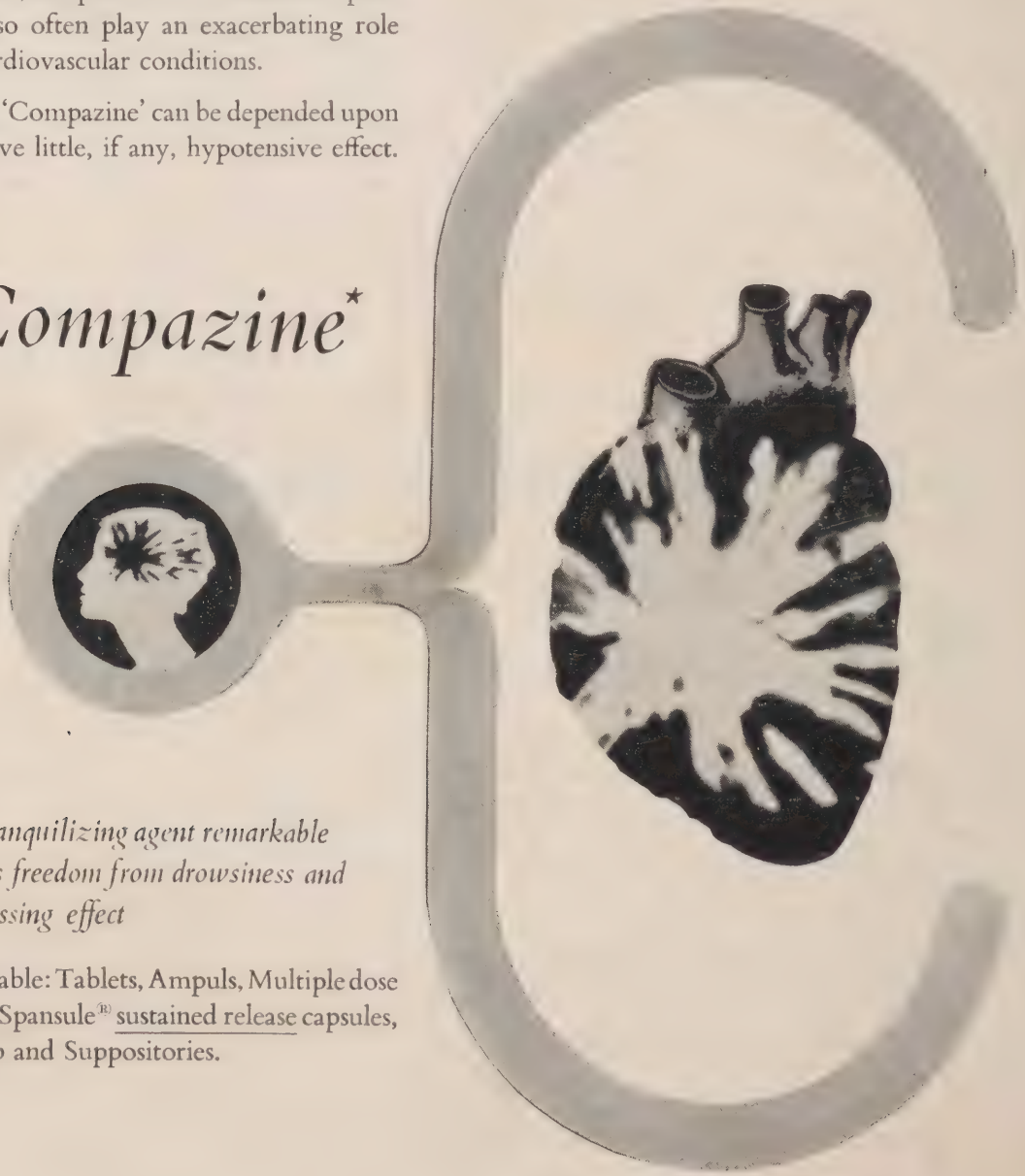
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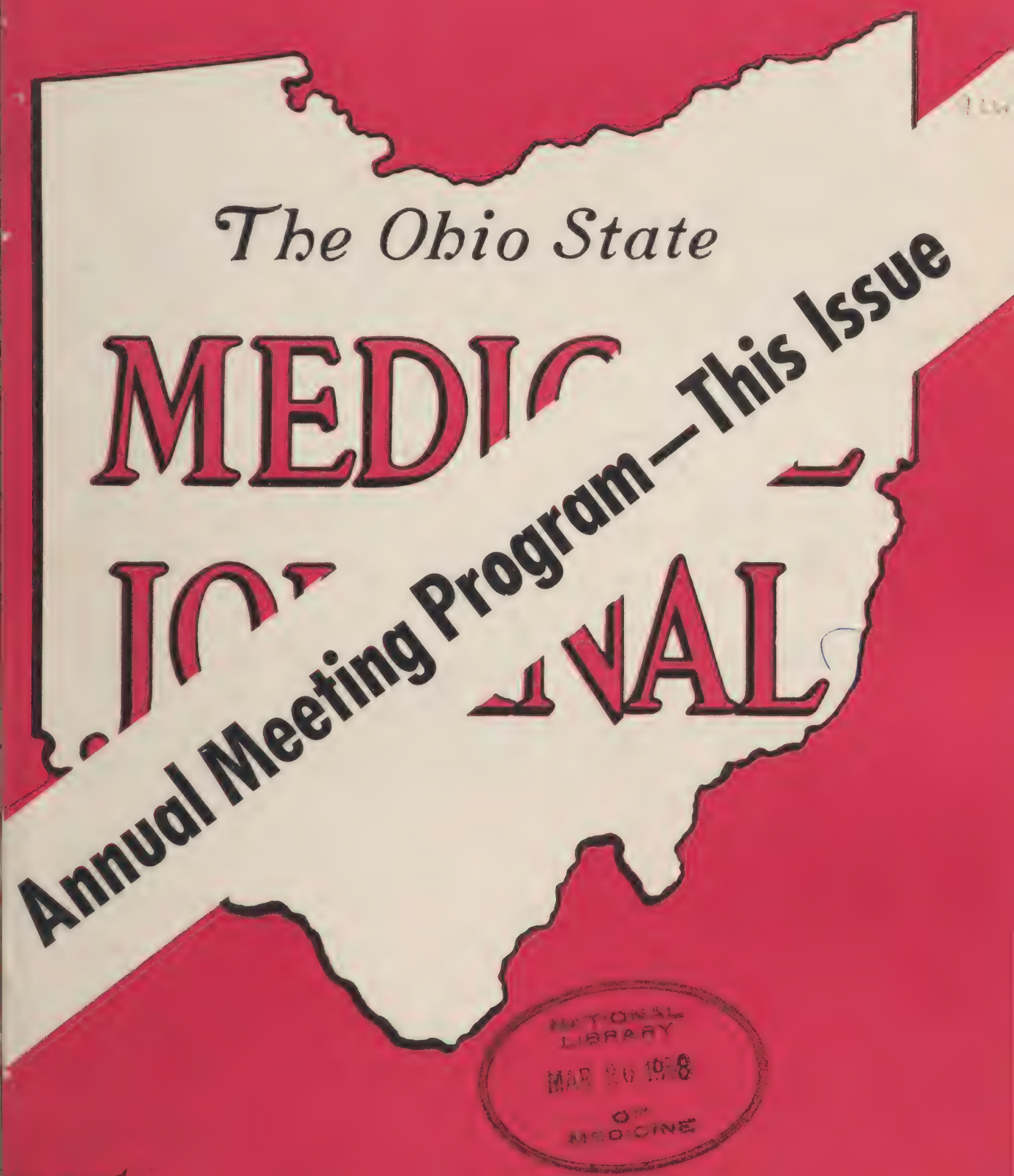
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Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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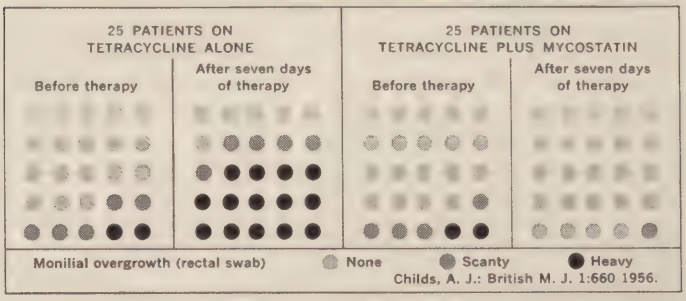
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Committee on School Health (1957-1958)—Thomas E. Shaffer, Columbus, Chairman; Charlotte Ames, Xenia; Elizabeth Rowland-Aplin, Columbus; Margaret E. Belt, Lima; Richard R. Buchanan, Wilmington; Walter Felson, Greenfield; Walter F. Heine, Circleville; Howard H. Hopwood, Jr., Cleveland; Dale A. Hudson, Piqua; Charles L. Kagay, Dayton; Robert A. Lyon, Cincinnati; Charles H. McMullen, Loudonville; Margaret O'Neal, Zanesville; J. M. Painter, Kent; Carl L. Petersilge, Newark; Robert C. Markey, Bowling Green; William S. Rothe, Bowling Green; Richard H. Schaefers, Wapakoneta; J. I. Rhiel, Port Clinton; H. B. Thomas, Gallipolis; J. W. Wilce, Columbus; Carl A. Wilzbach, Board of Health, City Hall, Cincinnati.

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Delegates and Alternates to the American Medical Association—Paul A. Davis, Akron; Edmond K. Yantes, Wilmington, alternate; Charles L. Hudson, Cleveland; C. E. Hufford, Toledo, alternate; Carl A. Lincke, Carrollton; H. M. Platter, Columbus, alternate; Carll S. Mundy, Toledo; Paul F. Orr, Perrysburg, alternate; L. Howard Schriver, Cincinnati; Charles A. Sebastian, Cincinnati, alternate; C. C. Sherburne, Columbus; Richard L. Meiling, Columbus, alternate; George A. Woodhouse, Pleasant Hill; R. Dean Dooley, Dayton, alternate; Herbert B. Wright, Cleveland; Fred W. Dixon, Cleveland, alternate.

County Societies' Officers and Meeting Dates

FIRST DISTRICT

ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—Donald L. Domer, President, Georgetown; Vytautas Karoblis, Secretary, Ripley. 1st Sunday, monthly.

BUTLER—John R. Perkins, President, Middletown; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Last Wednesday of alternate months.

CLERMONT—Richard D. Carr, President, Williamsburg; Harry M. Breuer, Secretary, New Richmond. Third Wednesday, monthly.

CLINTON—Roy D. Goodwin, President, Wilmington; H. Richard Bath, Secretary, Wilmington. 2nd Tuesday, monthly.

HAMILTON—George X. Schwemlein, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 152 East Fourth Street, Cincinnati 2. 1st and 3rd Tuesday, Sept. through May.

HIGHLAND—Glenn B. Doan, President, Greenfield; Kenneth Lyle Upp, Secretary, Greenfield. 1st Friday, monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

SECOND DISTRICT

CHAMPAIGN—John K. Pond, President, Urbana; William Pudvan, Secretary, Mechanicsburg. 2nd Wednesday, monthly.

CLARK—Elliott W. Schilke, President, Springfield; Martin J. Cook, Secretary, Springfield.

DARKE—V. Ray Boli, President, Greenville; Emmett W. Arnold, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Benjamin F. Lee, President, Xenia; Carl D. Hyde, Secretary, Yellow Springs. 2nd Thursday, monthly.

MIAMI Deane B. Armour, President, Bradford; Dale A. Hudson, Secretary, Piqua. 1st Friday, monthly, except June and July.

MONTGOMERY—Albert V. Black, President, Centerville; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton 2. 1st Friday, Jan., Feb., March, April, May and November; 1st Wednesday, June, October and December.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. Annual meeting only.

SHELBY—Thomas W. Hunter, President, Sidney; Ned A. Smith, Secretary, Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Walter E. Yingling, President, Lima; Thomas D. Allison, Secretary, Lima, 3rd Tuesday, monthly, except June, July and August.

AUGLAIZE—Robert J. Herman, President, Wapakoneta; Robert S. Oyer, Secretary, Wapakoneta.

CRAWFORD—Theodore D. Sawyer, President, Crestline; R. Douglas Myers, Secretary, Crestline.

HANCOCK—Frank M. Wiseley, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Louis A. Black, President, Kenton; William F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOGAN—Frederick W. Kaylor, President, Bellefontaine; Charles A. Browning, Jr., Secretary, Bellefontaine. 1st Friday, monthly.

MARION—Daniel M. Murphy, President, Marion; James A. Schuler, Secretary, Marion. 1st Tuesday, monthly, except June, July, August.

MERCER—Donald R. Fox, President, Celina; Robert F. Brashear, Secretary, Rockford.

SENECA—Harry P. Ulicny, President, Fostoria; Emmet T. Sheeran, Secretary, Fostoria. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

FOURTH DISTRICT

DEFIANCE—William S. Busteed, President, Defiance; Gerald A. Huber, Secretary, Defiance. 1st Saturday, monthly.

FULTON—Edwin R. Murbach, President, Archbold; Robert A. Ebersole, Secretary, Archbold. 4th Tuesday, monthly.

HENRY—Tony P. Delventhal, President, Napoleon; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday, monthly.

LUCAS—Harvey C. Gunderson, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; Robert W. Minick, Secretary, Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, Paulding; D. E. Farling, Secretary, Payne. 3rd Wednesday, monthly.

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WILLIAMS—Robert A. Gilreath, President, Bryan; Robert W. Dilworth, Secretary, Montpelier. 3rd Tues., monthly.

WOOD—Stewart J. Smith, President, Bowling Green; Richard L. Pearse, Secretary, Bowling Green.

FIFTH DISTRICT

ASHTABULA—Walter J. Brown, President, Conneaut; Robert J. Zimmerman, Secretary, Conneaut. 2nd Tuesday, monthly.

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

County Societies' Officers and Meeting Dates (Continued)

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown 3. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—David Danenberg, President, Bridgeport; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vorhies, Secretary, Scio. Meetings quarterly.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Shaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Don R. Johnson, President, Nelsonville; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Richard R. Hille, President, Marietta; Roy M. Meredith, Secretary, Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Ralph B. Burner, President, Gallipolis; George E. Files, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Robert M. Andre, President, Waverly; Mack E. Moore, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. 1st Monday after the 1st Tuesday.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Mary K. Kuhn, President, Ashley; Edward C. Jenkins, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, London; Paul G. H. Wolber, Secretary, London. 2nd Wednesday, monthly.

MORROW—Joseph P. Ingmire, President, Mt. Gilead; Lowell Murphy, Secretary, Cardington. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Harold V. Marley, President, Ashland; Myron A. Shilling, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—Owen J. Nicholson, President, Norwalk; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Charles F. Curtiss, President, Bellville; Harlin G. Knierim, Acting Secretary, Mansfield.

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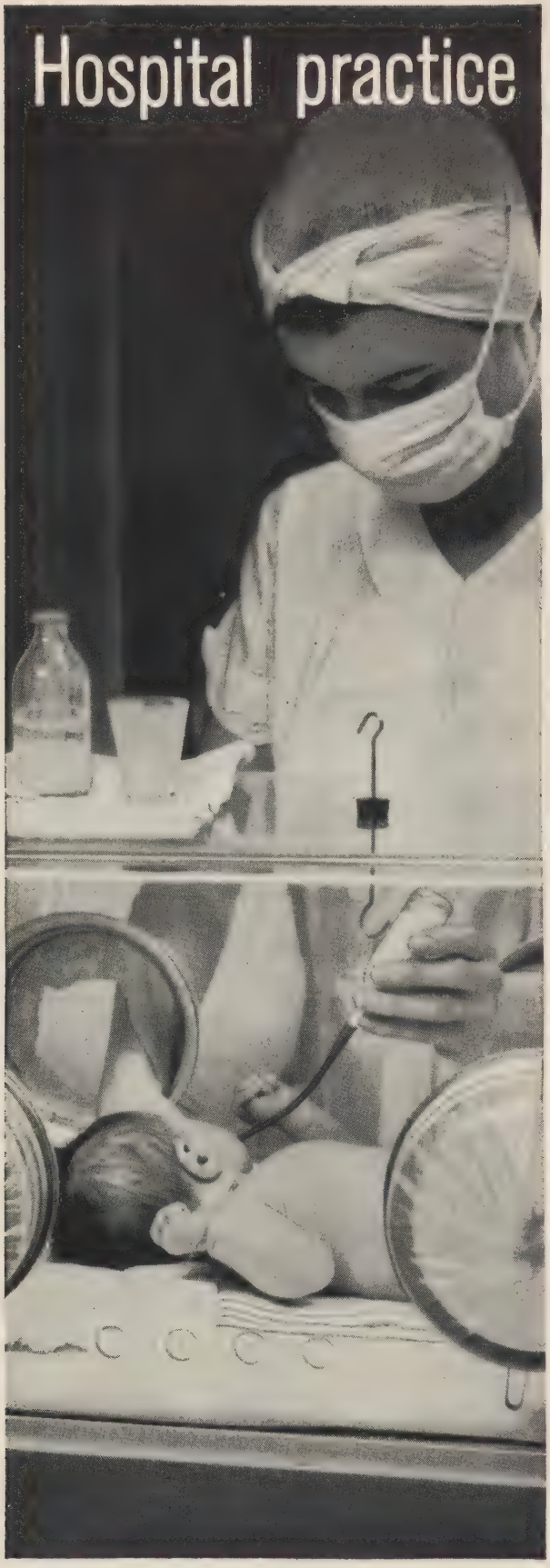
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Breast milk is satisfactory for the feeding of prematures in spite of the low protein and mineral and high fat content. But eventual formula feeding should provide a high protein and carbohydrate to satisfy the rapid-growing needs of the premature and low fat content because of limited digestive capacity.

Feedings of small prematures are most effectively administered by the indwelling polythene nasal catheter and of large prematures, by bottle with small nipples.

The first six feedings should be a sterile 5% solution of Karo Syrup at 2 to 3 hour intervals; for subsequent feedings, breast milk or formula should be added in gradually increasing amounts according to tolerance and requirements, as indicated in the table below.

Initial feeding schedules for premature infants

(Feedings Started After 36 Hours and Continued at 2 to 3 Hour Intervals)

FEEDINGS	COMPOSITION	QUANTITY
First Six	5% Karo	2-5 ml.
7th and 8th	2 parts 5% Karo 1 part breast milk or formula	6-10 ml.
9th and 10th	1 part 5% Karo 1 part breast milk or formula	8-15 ml.
11th and 12th	1 part 5% Karo 2 parts breast milk or formula	10-18 ml.
Subsequently	Breast or formula feeding	12-20 ml.

ADVANTAGES OF KARO® IN INFANT FEEDING



Composition: Karo is a superior maltose-dextrin mixture because the dextrins are non-fermentable and the maltose is rapidly transformed into dextrose which requires no further digestion.

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It is a single chemical substance, thoroughly tested and found particularly suited in the management of a wide range of conditions including psychotic, psychoneurotic and psychosomatic disturbances.

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Specifically, the usefulness of Dartal has been established in psychoneuroses with emotional hyperactivity, in diseases with strong psychic overtones such as ulcerative colitis, peptic ulcer and in certain frank and senile psychoses.

Usual Dosage • In psychoneuroses with anxiety and tension states *one 5 mg. tablet t.i.d.*

• In psychotic conditions *one 10 mg. tablet t.i.d.*

NEW "Single-Rx"

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- Symptomatic relief of aches, pains, fever, coryza, and rhinorrhea associated with upper respiratory tract infections.
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MEDICATION

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TETREX (tetracycline phosphate complex) ..... 125 mg.
(tetracycline HCl activity)

An established analgesic-antipyretic combination

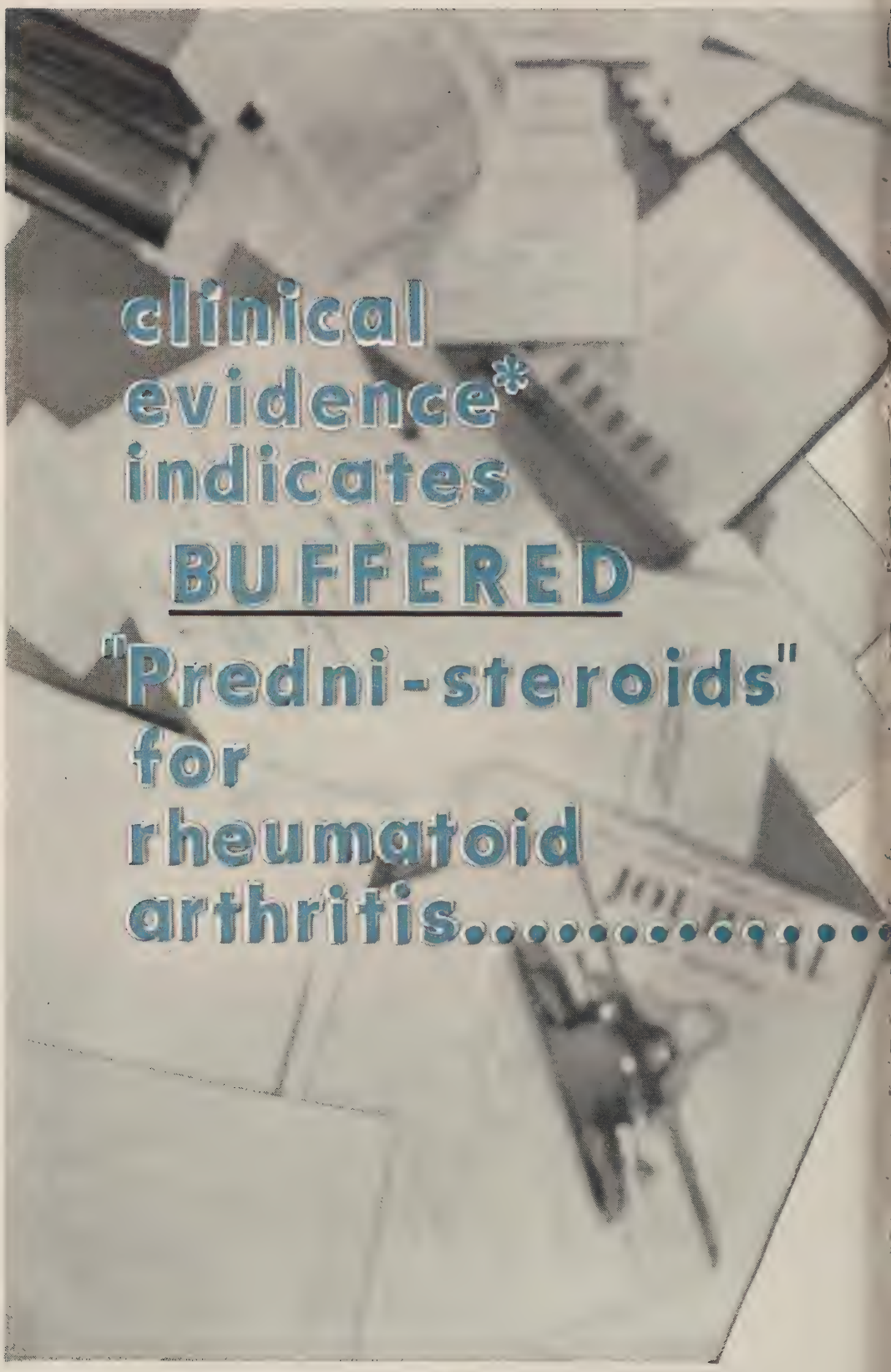
Aspirin ..... 150 mg.
Phenacetin ..... 120 mg.
Caffeine ..... 30 mg.

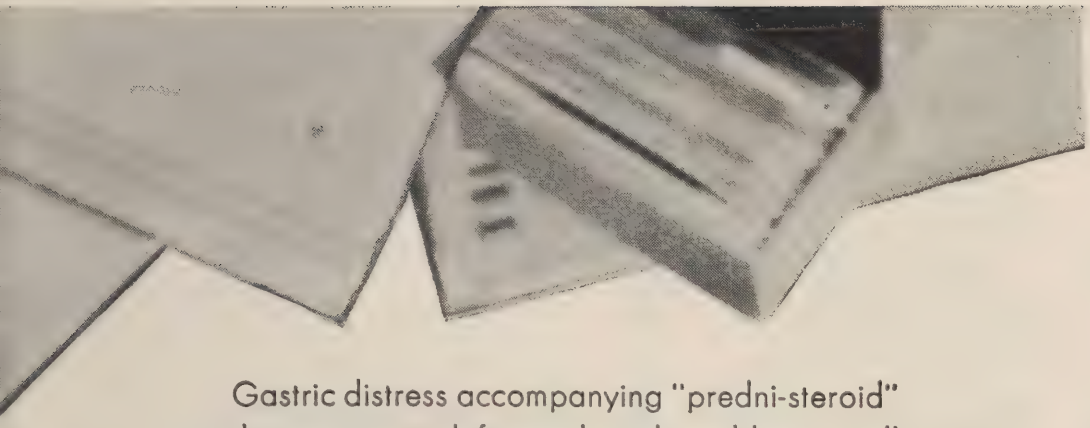
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Dosage: *Adults:* 2 capsules at onset of symptoms, followed by 2 capsules 3 or 4 times a day for 3 to 5 days. *Children, 6 to 12 yrs.:* One-half adult dose.

Supplied: Bottles of 24 and 100 capsules.


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*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

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With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

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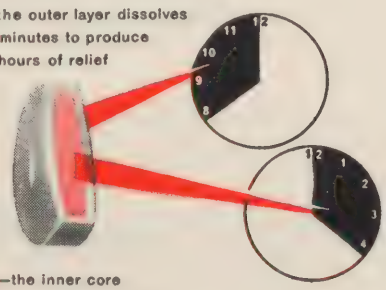
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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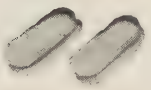
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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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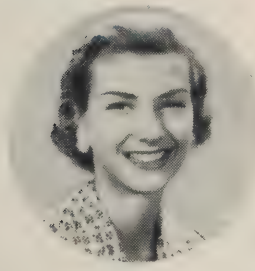
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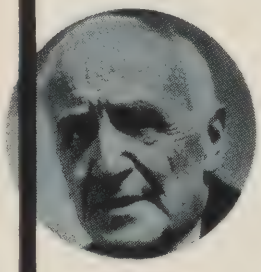
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FILMTAB®

Erythrocin®

STEARATE (Erythromycin Stearate, Abbott)

against staph-, strep- and pneumococci



Indications

ERYTHROCIN is indicated in treating infections caused by staphylococci, streptococci (including enterococci), and pneumococci. Indicated also, in treating infections that have become resistant to other antibiotics. May be used for patients who are allergic to penicillin or other antibacterials.

Dosage

Usually administered in a total daily dose of 1 to 2 Gm., depending on severity of infection. Suggested dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours.

Supplied

In bottles of 25 and 100 *Filmtabs* (100 and 250 mg.). Also, in tasty, cinnamon-flavored oral suspension, in 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

®Filmtab—Film-sealed tablets, Abbott; pat. applied for.



REMARKABLE EFFECTIVENESS PLUS A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY TODAY

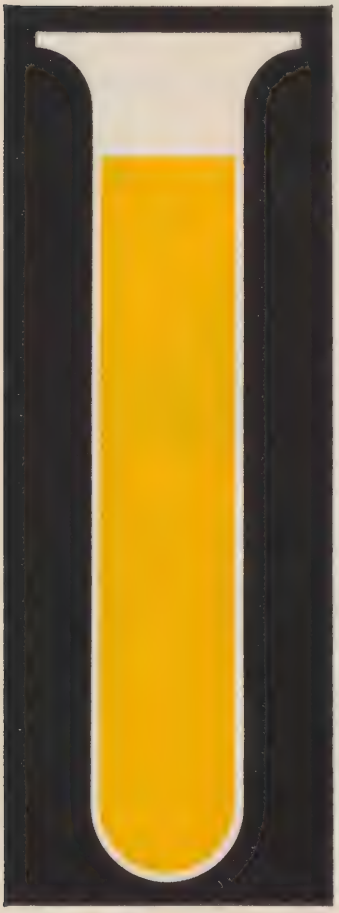
Actually, after almost six years of extensive use, there has not been a single report of a serious reaction to ERYTHROCIN. And, after all this time, the incidence of resistance to ERYTHROCIN has remained exceptionally low.

You'll find ERYTHROCIN is highly effective against the majority of coccal infections and may also be used to counteract complications from severe viral attacks. It comes in *Filmtabs* and in Oral Suspension. Abbott

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Compocillin-V®

for those penicillin-sensitive organisms



Indications

Against all penicillin-sensitive organisms. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and in rheumatic heart disease.

Dosage

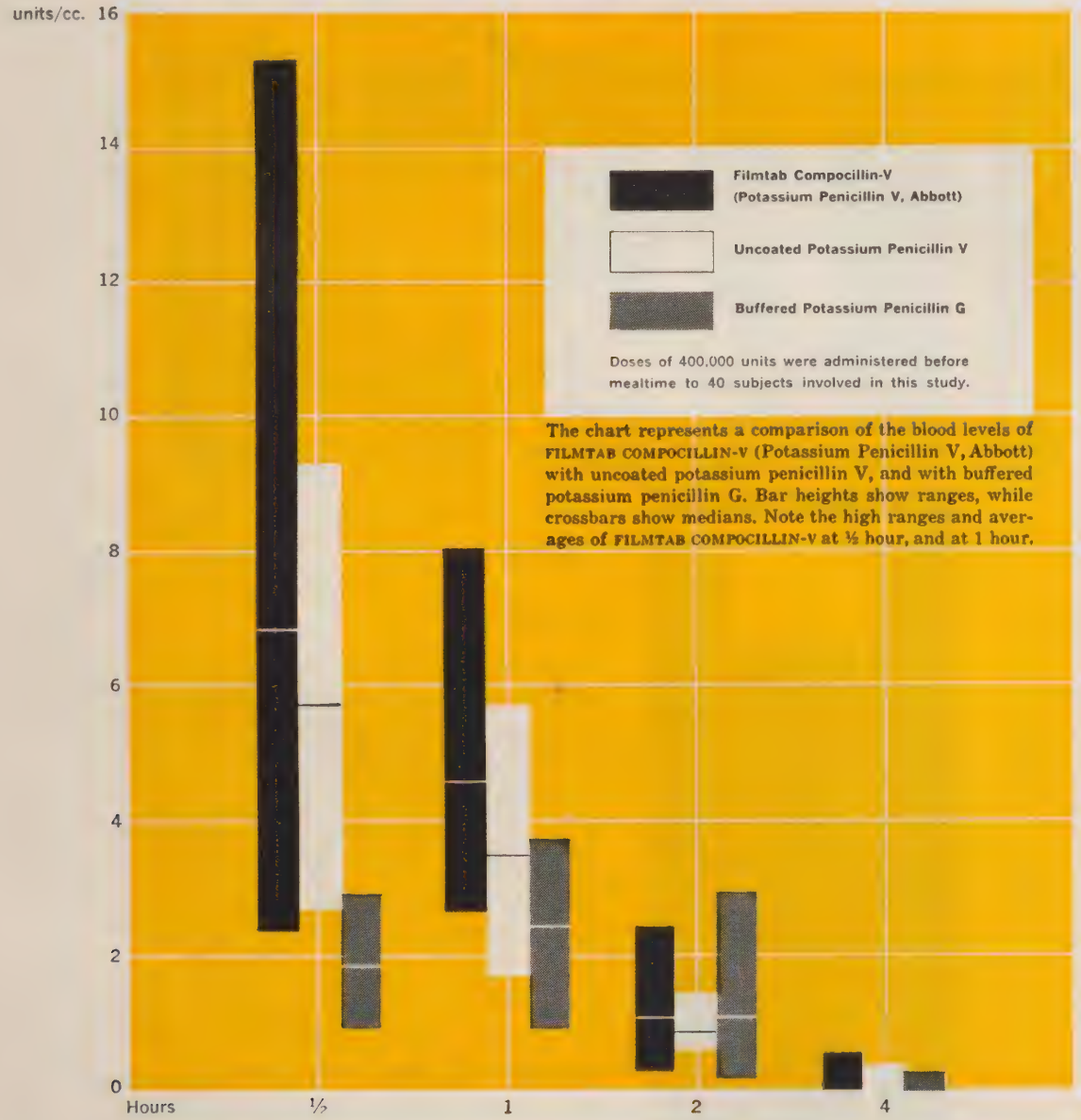
Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

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THE HIGHER BLOOD LEVELS OF COMPOCILLIN-V
—IN EASY-TO-SWALLOW FILMTABS AND TASTY, ORAL SUSPENSION



The chart represents a comparison of the blood levels of FILMTAB COMPOCILLIN-V (Potassium Penicillin V, Abbott) with uncoated potassium penicillin V, and with buffered potassium penicillin G. Bar heights show ranges, while crossbars show medians. Note the high ranges and averages of FILMTAB COMPOCILLIN-V at ½ hour, and at 1 hour.

Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

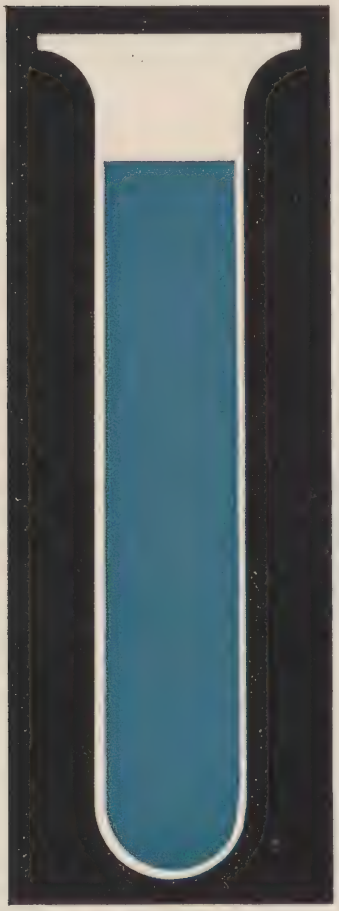
COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed – stays stable for at least 18 months.

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Spontin®

(Ristocetin, Abbott)

and when coccal infections hospitalize the patient



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Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED



SPONTIN comes to the medical profession with a clinical history of dramatic results — cases where the patients were given little chance of survival.

During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity — no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare — and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients — does your hospital have it stocked?

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Obstetric Practice, by Harold Speert, M. D., and A. F. Guttmacher, M. D. ($7.00. *Landsberger Medical Books Inc.;* distributed by *Blakiston Div., McGraw-Hill Book Co., New York 36, N. Y.)* This is the fourth volume in the series of Handbooks for the General Practitioner.

Police Drugs, by Jean Rolin, translated by L. J. Bendit, M. D. ($4.75. *Philosophical Library, New York 16, N. Y.)* Based upon a notorious post-liberation trial in France in which "truth-drugs" were grossly misused. The author considers it illustrates all the dangers involved in extracting confessions by the use of drugs.

Clinical Roentgenology; Volume IV: The Digestive Tract, The Gall Bladder, Liver, Pancreas and Excretory Tract, by A. A. DeLorimier, M. D., H. G. Moehring, M. D., and John Hannan, M. D. ($24.50, *C. C. Thomas Publisher, Springfield, Ill.)* This volume contains 764 pages with 1112 illustrations and has its own index. It is well printed with its illustrations in the same tone as the original negatives with emphasis upon practical aids and differential diagnosis.

Scientific Hypnotism, by Ralph B. Winn, Ph. D. ($2.00, paper. *Wilshire Book Co., 8721 Sunset Blvd., Los Angeles 46, Calif.)* The author, a professional hypnotist as well as a professor of psychology, attempts to arouse our interest in hypnotism as the greatest power yet known for influencing the human mind. Using the mass of knowledge and the theories behind it, this pioneer scientist predicts its increasing use in medicine, psychology and education.

Science and Surgery, by Frank G. Slaughter, M. D. (35 cents. *Perma Books, New York 20, New York.)* A pocket edition by this noted writer and surgeon telling how the surgical wonders are performed that bring life and health to modern man.

Year Book of Obstetrics and Gynecology, 1956-57, edited by J. P. Greenhill, M. D. ($6.75. *The Year Book Publishers, Inc., Chicago 11, Ill.)* A complete summary of the year's literature with comments by its wise old editor on the important developments.

Enzyme, Antigen and Virus: A Study of Micromolecular Patterns in Action, by Sir Macfarlane Burnet. ($3.50. *Cambridge University Press, New York 22, N. Y.)* One of the central problems of the present-day biology is that of protein synthesis; not so much from the purely chemical angle as in terms of the process by which functional significance is conferred upon the molecule. Enzymes, antibodies and viruses are or contain protein molecules of highly specific functional activity, easily demonstrable by appropriate biological tests, but not as yet expressable in chemical terms. In this monograph the author attempts to find common factors in what is known about the production of adaptive enzymes, the stimulation of antibody production by antigen and the intercellular multiplication of influenza and other viruses.

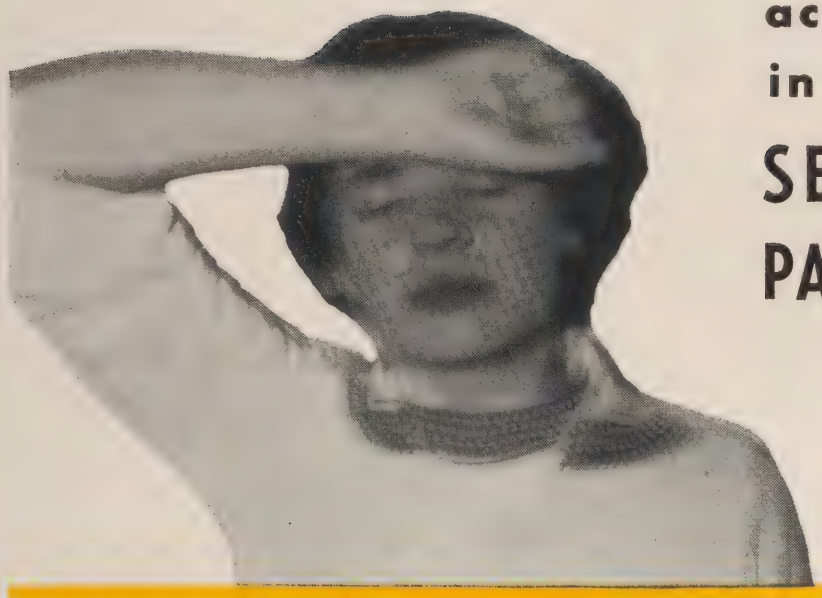
The Doctor's Widow: A Story of a Good Neighbor, by William M. Queen. ($3.25. *Academy Library Guild, P. O. Box 54, Fresno, Calif.)* It is the story of Mother Luisa who was well known for her work in Los Angeles. Her wisdom is made manifest by the progress of her spiritual daughters in her native country in Mexico and in California.

Problems of Adolescents, by Harry Edelston, M.D. ($4.75. *Philosophical Library, New York 16, New York.)* This is the record of an experiment in sex education carried out among youth clubs during the last 15 years. The author, a psychiatrist and for many years director of the Bradford Child Guidance Clinic, has been closely associated with youth groups of various ages and denominations of faith. He shows himself to be a firm believer in the need for religious principles as the ultimate basis for moral behavior. The experiment devised by the author took the form of a general lecture given to a mixed audience of adolescents on the psycho-biology of sex. This served to provoke questions on personal problems and these were sent in anonymously in writing and were discussed at subsequent meetings by the author and audience. They showed with astonishing clarity the many vivid and sometimes unexpected problems facing the modern adolescent.

Clinical Psychology, by Richard W. Wallen, Ph. D. ($6.00. *McGraw-Hill Book Co., New York 36, N. Y.)* This is a study of persons, illustrated with interesting case histories. It has been written by an Associate Professor in the Western Reserve University. Stress is laid on using many different kinds of information about persons in a creative way.

Biochemical Aspect of Fertilization, by Lord Rothschild, Sc. D. ($3.50. *John Wiley & Sons, New York 16, N. Y.)* The subject is the life of

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ORAL — 1 tablet t.i.d. or q.i.d.

SUPPLIED:

VIALS, 10 cc. and 30 cc. TABLETS, bottles of 100 and 1000.

*Joseph, Morris: Effective Analgesia Without Sedation or Narcosis, Clinical Medicine, August 1957.

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the egg from the attachment of the fertilizing spermatozoon to the fusion or apposition of the male and female pronuclei. It is intended to be read after or along with standard texts on experimental cytology, general physiology and the physical chemistry of cells.

The Practice of Psychosomatic Medicine: As Illustrated in Allergy, by Hyman Miller, M. D., and Dorothy W. Baruch, Ph. D. ($5.00. *Blakiston Division, McGraw-Hill Book Co., New York 36, New York.)* This is an extremely controversial book among allergists who themselves often overemphasize the psyche at the expense of the soma. It represents, however, the thinking of a segment of the allergists and the students of psychosomatics and therefore is informative as well as marking a milestone in the history of one segment of medicine.

Physiological Studies of Infantrymen in Combat, by staff of the Department of Physiology and the office of Naval Research Unit No. 1, University of California, Berkeley, as well as the Worcester Foundation, The Naval Institute, Johns Hopkins, University of Illinois and the Research Laboratory for Arthritis at University of California. ($1.50. *University of California Press, Berkeley 4, California.)* Both the anticipation of combat and the acute combat itself were found to evoke a profound response of the adrenal cortex persisted for at least 12 hours after the experience. The effects of a prolonged combat period of several days, on the other hand, while similar in some respects to those of acute combat, appear to differ in others. When tested 10 days later, the men of prolonged combat had only partially recovered.

Guide to Medical Terminology, by Wallace and Ann Clark, medical editors. ($1.50. *F. A. Davis Co., Philadelphia 3, Pa.)* This book is designed to assist in the understanding of medical language. By listing in tabular form the prefixes, the suffixes, along with the word and its meaning, and the make-up, it makes the long words of our vocabulary seem simple and easy to understand.

Review of Medical Microbiology, by Ernest Jawetz, M. D., Joseph Melnick and Edward Adelberg. ($4.50, 2nd edition. *Lange Medical Publications, Los Altos, Calif.)* This review makes available a brief, adequate, up-to-date presentation of its aspects which are of particular significance in the fields of clinical infections and chemotherapy.

Chemosurgery in Cancer, Gangrene and Infections, by Frederic E. Mohs, M. D. ($13.00, *C. C. Thomas Publisher, Springfield, Ill.)* The book features a new method for the microscopically controlled excision of cancer with thoroughly documented statistics on the five year end results in a large series of cases.

Wire Brush Surgery, by James W. Burks, Jr., M. D. ($6.75, *C. C. Thomas Publisher, Springfield, Ill.)* This is the first modern monograph on the new techniques for cosmetic improvement of the scars of acne and other skin disfigurements.

Anesthesia for Surgery of the Heart, by K. K. Keown, M. D. ($3.75, *C. C. Thomas Publisher, Springfield, Ill.)* This monograph is based upon ten years practice dealing with patients prior to, during and immediately after surgery on the heart in one of the world's leading Cardiac Centers. It is a ready reference for all concerned with the selection and management of these patients.

Neurological Nursing, by John Marshall, M. D. ($3.75, *C. C. Thomas Publisher, Springfield, Ill.)* This book has been written by an Edinburgh Neurologist for all those who are concerned with the final management of patients suffering from neurological diseases.

The Physiological Foundation of Dental Practice, by L. L. Langley, Ph. D., and E. Cheraskin, M. D., D. M. D. ($9.75, 2nd edition, *C. V. Mosby Co., St. Louis, Mo.)* This book is an earnest experiment in teaching Physiology to dental students.

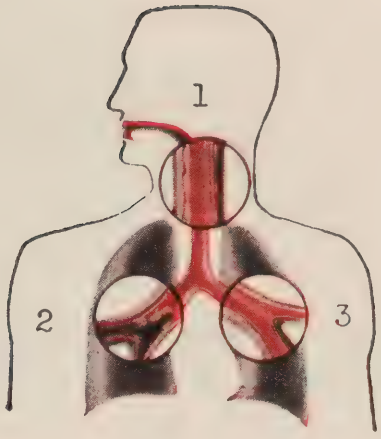
Sick Children, Diagnosis and Treatment, by Donald Paterson, M. D. ($8.75, 7th edition, *J. B. Lippincott Co., Philadelphia 5, Pa.)* This book has been completely revised since the last edition in 1949. This British-Canadian text has been thoroughly revised by Reginald Lightwood, M. D., of London, England.

Observations on Krebiozen in the Management of Cancer, by A. C. Ivy, M. D., John F. Pick, M. D., and W. F. P. Phillips, M. D. ($2.50. *Henry Regnery Company, Chicago 4, Ill.)* A great deal has been written about Dr. Ivy and Krebiozen but this is the first public report by him on the results of his investigation. It is an objective attempt at appraisal. All who have any interest in cancer will want to read this book very carefully.

Implementation of Clinical Instruction in Medical and Surgical Nursing, by Sister Constantia Clark, R. N., and A. D. Schweitzer, R. N. ($3.50, *Catholic University of American Press, Washington 17, D. C.)* This is the second proceedings of a workshop held at the University. Among those participating was Eileen Downing, Director of Nursing at Benjamin Franklin Hospital in Columbus, Ohio.

Clinical Unipolar Electrocardiography, by B. S. Lipman, M. D., and Edward Massie, M. D.

breaks up cough*



* Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). **C I B A**

(\$7.50, 3rd edition, *Year Book Publishers, Chicago 11, Illinois)* The increasing interest in heart disease and the accompanying advancement in electrocardiography have created a need for a third edition of this well known text.

Progressive Practice in Dentistry, by Edward Samson. (\$7.50, 3rd edition, *Philosophical Library, Inc., New York 16, N. Y.)* Of interest to all who would like to know more about dentistry as it is practiced privately and under national health service.

Urology and Industry, by L. P. Wershub, M. D. (\$5.00, *C. C. Thomas Publisher, Springfield, Ill.)* The diagnosis and treatment of the diseases in this field are related by the author to the interpretation and administration of the laws governing the responsibility of employers for the ills and injuries of their employees. The book includes 100 selected cases pointing out the medical-legal problems in the field of Urology under the Workmen's Compensation Law.

Nerve Impulse, by David Nachmansohn, M. D., and Houston Merritt, M. D. (\$4.50, *Josiah Macey Jr. Foundation, Packanack, New Jersey.)* This is the Proceedings of the Fifth Conference sponsored by this foundation upon this topic.

How to Overcome Colitis, by Joseph F. Montague, M. D. (\$4.00, *Citadel Press, New York 3, New York.)* This well known author on constipation and large bowel behavior gives here an intimate and sympathetic presentation and facts that a patient should have who is a victim of colical disorders.

Clinical Pathology; Its Application and Interpretation, by B. B. Wells, M. D. (\$8.50, 2nd edition, *W. B. Saunders Co., Philadelphia 5, Pa.)* It is a practical guide for medical students and physicians. The material is arranged as it will be used, beginning with the problems of tests that might be useful and the proper meaning of the procedures and a definition of their limitations.

Medicine in Action; Today and Tomorrow, by Margaret O. Hyde. (\$2.75, *Whittlesey House, McGraw-Hill Book Co., New York 36, N. Y.)* This is designed to inspire an interest in the young in the activities in medicine. Its problems, its ideals, its triumphs, and its conquest over pain and suffering.

Paper Electrophoresis, by G. E. W. Wolstenholme M. B., and Elaine C. P. Millar. (\$6.75, *Little Brown and Co., Boston 6, Mass.)* This is a Ciba Foundation Symposium, and it is the first book in which the world's leading experts present their work together in this field.

Bone Structure and Metabolism, by G. E. W. Wolstenholme, M. B., and Cecilia M. O'Connor. (\$8.00, *Little Brown and Co., Boston 6, Mass.)* It is a Ciba Foundation Symposium. It begins with the fundamental approach to structure and metabolism of bone; from this it proceeds through biochemistry, physiology, and finishes with clinical medicine.

Bing's Local Diagnosis in Neurological Diseases, by Webb Haymaker, M. D. (\$16.75, *C. V. Mosby Co., St. Louis, Mo.)* This is the second English edition of the original 1909 work of Robert Bing. The text has been freshened through amplification both in text and illustrations.

Clinical Psychologist, by William A. Hunt, M. D. (\$5.50, *C. C. Thomas Publisher, Springfield, Ill.)* The book contains the three Thomas William Salmon lectures for 1954. It discusses the place of clinical psychology in American psychology and makes explicit some of its motivations and orientations. It also discusses techniques and education.

Pott's Paraplegia, by D. L. Griffith, M. D., H. J. Seddon, M. D., and R. Roof, M. D. (\$12.75. *Oxford Book Company, New York 3, N. Y.)* The three authors of this short monograph have combined to present their common views of the management of this condition. They express concern over the failure of conservative treatment in a large proportion of cases and dismay by the futility of many of the operations undertaken for its relief. They are for the antero-lateral decompression of the spinal cord.

Personality, Stress and Tuberculosis, by P. J. Sparer, M. D. (\$12.50, *International Universities Press Inc., New York 11, N. Y.)* This book is sponsored by American College of Chest Physicians and is the first book making available under one cover, the extensive current development in medical and psychical sciences that bear on the subject of tuberculosis.

Basic Readings on the M. M. P. I. in Psychology and Medicine, edited by George Schleger Welsh, Ph. D., M. D., and W. G. Dahlstrom. (\$8.75, *University of Minnesota Press, Minneapolis 14, Minn.)* The Minnesota Multiphasic Personality Inventory has been the subject of hundreds of articles since those introduced 15 years ago. This book makes available 66 of the most important articles together with a bibliography of over 700 titles.

Clinical Examinations in Neurology, by members of the Sections of Neurology and Physiology at the Mayo Clinic. (\$7.50, *W. B. Saunders and Co., Philadelphia 5, Pa.)* Sixteen of the staff

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COUNTERACT DEPRESSED MOODS *without stimulation*

- Relieves depression without euphoria
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Average Adult Dose: 1 tablet q.i.d.

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Literature and samples on request

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have made specific contributions to this book. It has the practical purpose of presenting the subject to those fellows at the clinic who are taking their training in Neurology.

Fractures, Dislocations and Sprains, by J. A. Key, M. D., and H. E. Conwell, M. D. ($20.00, 6th edition. *C. V. Mosby Co., St. Louis 3, Mo.)* This book has served the profession well for the last 28 years. This silver anniversary edition has been carefully revised, old methods eliminated and new ones presented.

American Medicine, edited by George M. Piersol, M. D. ($11.50, *F. A. Davis Co., Philadelphia 3, Pa.)* Because of their wide experience in good judgment the carefully selected contributors to this service volume give us an adequate view of the great mass of literature appearing in recent years.

Diseases of the Heart, by Charles K. Friedberg, M. D. ($18.00, 2nd edition, *W. B. Saunders Company, Philadelphia 5, Pa.)* The first edition of this book was well received and in this second edition, three chapters devoted to graphic methods have been added. Major revisions have been made in the section dealing with surgery and several other subjects have been greatly expanded so that we now have a book of 1161 pages.

Year Book of Pediatrics: 1956-57, edited by Sydney S. Gellis, M. D. ($6.75. *Year Book Publishers, Chicago 11, Ill.)* The high points of the attractive and authoritative review are the declining rate of retrolental fibroplasia, increased resistance to antibiotics of staphylococci, danger of radiation and man-made diseases.

Psychologic Aspects in the Care of Infants and Children, edited by W. O. Robertson, M. D. (Apply, *Ross Laboratories, Columbus 16, Ohio.)* This is the 21st pediatrics research conference sponsored by the manufacturers of Similac® held under the auspices of the department of Pediatrics of Yale University.

The Medico-Legal Reader, by Samuel Polsky, LL. B., Ph. D. ($1.00 paper, *Oceana Publications, 43 W. 16th St., New York 11, N. Y.)* One of Temple University studies in Law and Medicine. The major features of medico-legal medicine are presented in an interesting manner.

Health Insurance: Group Coverage in Industry, by Richard N. Baisden and John Hutchison. (25 cents. *Institute of Industrial Relations; University of California, Los Angeles 24, Calif.)* A popular pamphlet designed for labor organization, management, and the general public and a report of the Institute's investigations into the problem of medicine for workers and their dependents.

Foundations of Nutrition, by Clara Mae Taylor, Ph. D., Grace Macleod, Ph. D., and the late Mary Swartz Rose, Ph. D. ($6.00, fifth edition, *The Macmillan Company, New York 11, N. Y.)* It is 13 years since the fourth edition appeared and much progress has been made. As with the previous editions the book is aimed at those who wish "to live more intelligently." It attempts to give the fundamental principles of human nutrition in terms which call for no specialized scientific training.

How to Enjoy Good Health, by Cyril Solomon, M. D., and Brooks Roberts. ($3.95, *Random House, New York 22, N. Y.)* Some 67 physicians, experts in the various fields, have contributed to this volume. Each article was originally prepared for the series on preventive medicine which ran in the magazine *This Week.* The American Medical Association assisted in the preparation and review of this series. It is authoritative and timely.

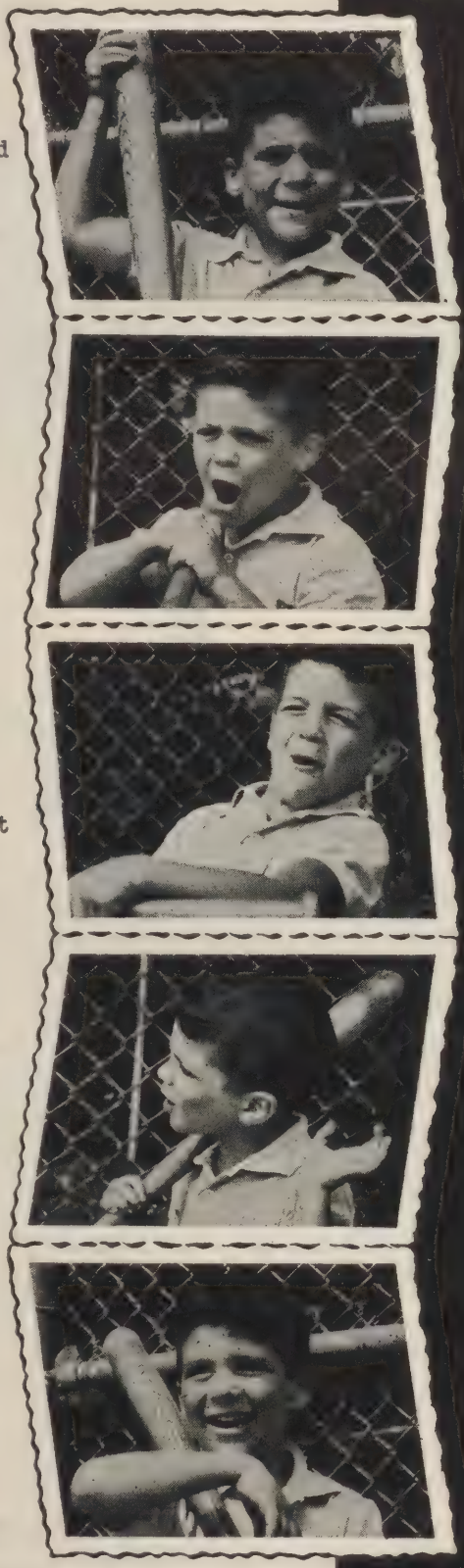
The Magic of Balanced Living, by John W. Tebbel. ($3.50, *Harper and Brothers, New York 16, N. Y.)* A man's key to health, well-being and peace of mind. Urologist A. C. Drummond of Bellvue has said in his introduction the author "gives the reader intelligent and well-balanced information as to how medicine is helping all of us to live healthier."

Pediatrics, by Donald Paterson, M. D., and John Ferguson McCreary, M. D., with 36 contributors. ($14.00. *J. B. Lippincott Co., Philadelphia 5, Pa.)* A text designed to fit between the excellent consultant texts in the subject and the small books of a more tabular type which have become available in recent years. It offers the man in general practice what he wants to know in a form that he can use.

Neurological and Neurosurgical Nursing, by C. G. de Gutierrez-Mahoney, M. D., and Esta Carini, R. N. ($6.25, second edition, *C. V. Mosby and Co., St. Louis 3, Mo.)* With the increased need for expert neurological and neurosurgical nursing this has its first edition exhausted and a second has been prepared to keep pace with this rapidly developing and growing field.

The Popular Medical Encyclopedia, Revised and enlarged, by Morris Fishbein, M. D., Editor. ($4.95. *Doubleday and Co., Garden City, New York.)* This is an easy-to-use, clearly written, and what is more important, authoritative medical reference for the layman.

MY DAD— HE HURT HIS BACK REAL BAD



"It happened at work while he was putting oil in something"

"He told Mom his shoulder felt like it was on fire"

"He couldn't swing a bat without hurting"

"But Doctor gave him some nice pills--and the pain went away fast"

"Dad said we'd play ball again tomorrow when he comes home"

AND THE PAIN WENT AWAY FAST

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ACTS FASTER...
usually within 5-15 minutes

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MORE THOROUGH RELIEF...
permits uninterrupted sleep through the night

RARELY CONSTIPATES...
excellent for chronic or bedridden patients

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New "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Available through all pharmacies.

Each PERCODAN® Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Literature? Write

Endo®

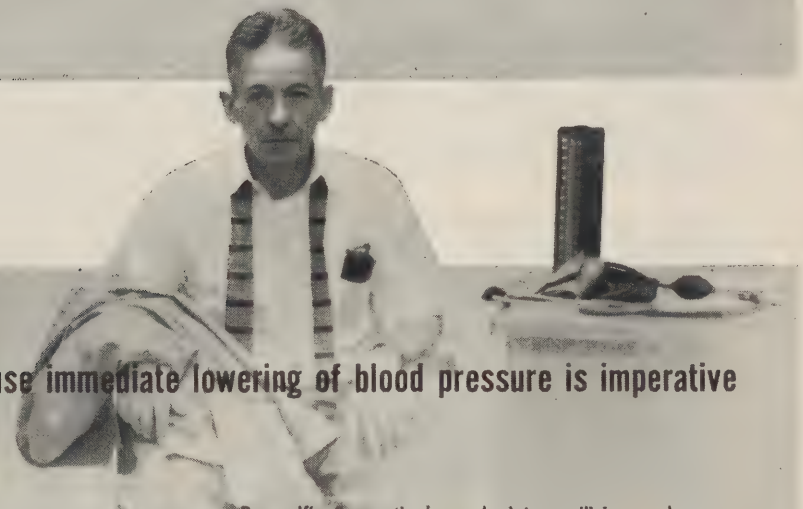
ENDO LABORATORIES
Richmond Hill 18, New York

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diagnosis: **hypertension, moderate to severe**

prescribed: **Rauprote***

(Rauwolfia Serpentina and Protoveratrines A & B Combined)



because immediate lowering of blood pressure is imperative

Rauwolfia Serpentina's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protoveratrine for effective therapy with a minimum of risk. Each of the agents appears to potentiate the other's hypotensive activity and produce beneficial vasodilitation, without ganglionic or adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which control blood distribution and which normally prevent postural hypotension.

Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

supplied: in bottles of 100 and 1000 tablets, each containing 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (the chemically standardized alkaloid of Veratrum Alba), or on prescription at leading pharmacies

VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*

PHARMACEUTICALS

*Trade Mark

You and Your Public . . .

Physician Would Do Well To Explain to Hospital-Bound Patient Medical and Economic Aspects of What Lies Ahead

KNOWLEDGE brings confidence, and unfamiliarity breeds anxiety. Pursuant to this thought, the physician who briefs his hospital-bound patient on what lies ahead can contribute considerably to the patient's peace of mind and assurance.

This applies particularly to the person who is about to undergo his first experience as a hospital patient. Too often he is totally unaware of what to expect—and what is expected of him. Furthermore, he is unfamiliar with hospital procedures and schedules.

It is important to the physician's patient relations (in effect, the physician's most important public relations) that he take the time to draw a form of "road map" for the patient to follow.

When this is done, the patient enters the hospital prepared for his stay there. He knows that he must register, and he knows what information he is asked to provide in registering. How much better this is than to have the unsuspecting patient suddenly find himself confronted with a barrage of questions when all he expected was to be assigned a bed.

Frank Discussion Best

The physician should discuss hospital routines and policies with his patient. Likewise, he should discuss the forthcoming treatment, be it medical or surgical. This discussion need not be a detailed analysis of every step, but it should contain a general outline.

Such details may appear trivial to the physician, but it must be remembered that the doctor spends considerable time at his hospital; the patient may be encountering his first experience there. Further, the patient feels that his doctor thinks of him as a person, and not just an assemblage of living tissues.

Here are some of the other aspects that could be explained by the physician:

Costs—This is one of the most misunderstood factors in hospitalization. There still are many people that have very little knowledge of the various costs involved.

Two Types of Costs

The physician should explain that there are two types of costs involved, direct medical and hospital. Further, the patient should be made to know that there may be fees for laboratory work, anesthesia, and other such contingencies.

Consultation—This again can be misunderstood. If consultation is indicated, tell the patient. Also, tell him that this can mean a fee.

Hospital visits—Policies of the hospital concerning visiting hours and limitation on the number of visitors at any given time are understandably necessary. Explain the policies. Then, later on, when a friend tells the patient, "I was out to see you when you were in the hospital, but they wouldn't let me in," the patient will know why, and understand.

Discharge—The patient should know that he will be expected to take care of his hospital bill at the time of his discharge, whether he wants to pay the bill outright, make arrangements for periodic payments or arrange for payment by his insurance carrier. Advance knowledge of this can facilitate discharge procedure. It will send the patient home in a better frame of mind.

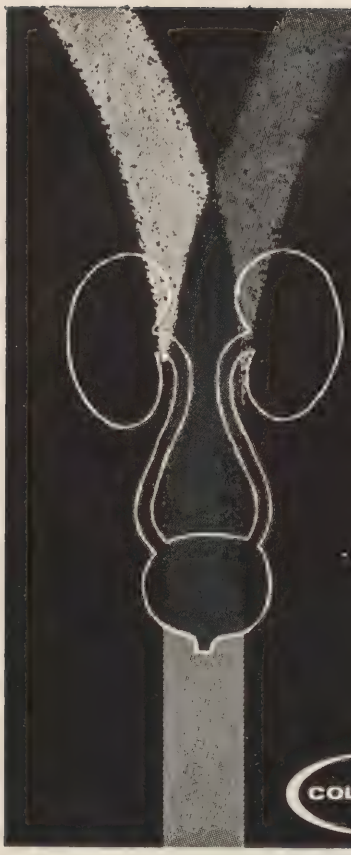
Follow-Up Important

Follow-up—Even if the physician dismisses the patient from his care at the time of discharge from the hospital, follow-up is an important consideration. This can be in the form of a house call or an office call, if necessary. If neither is necessary, a telephone call to inquire "how Mr. Jones is getting along" means something to Mr. Jones. It also builds the doctor's PR rating.

Some local medical societies provide their members with printed leaflets concerning hospitalization, these leaflets being distributed to each hospital-bound patient. The leaflets cover, briefly but clearly, some of the aspects discussed herein.

People are inclined to blame doctors for all medical costs—hospital room charges, laboratory work, medication in the hospital, and others. To combat this, some medical societies have developed cost estimate sheets, with the cooperation of local hospitals. Of course, it is emphasized that such sheets are for estimate purposes, only, and not actual costs.

Whether the individual physician handles this problem by word of mouth or printed leaflets, he is building a sound public relations foundation for his practice.



...IN URINARY COMPLAINTS

- Sterilizes urine in 1 to 3 days
- Relieves burning in minutes
- Effective in 93-98% of cases

sulfid*

The original Azo-Sulfa Formula* • Antibacterial • Analgesic

LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl—acts solely on the urogenital mucosa, provides prompt relief from burning, pain and frequency.

LOCALIZED ANTIBACTERIAL ACTIVITY

Sulfacetamide—eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.

...and when Spasmolysis is essential

sulfid* B-A

Antibacterial • Analgesic • Antispasmodic

—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

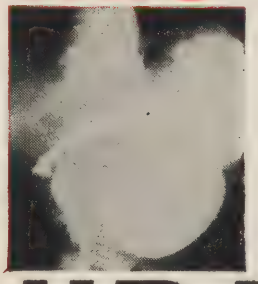
Introduced—July, 1954

COLUMBUS PHARMACAL COMPANY COLUMBUS 16, OHIO

---

when anxiety and tension "erupts" in the G. I. tract...

IN GASTRIC ULCER



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of gastric ulcer — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. ***Supplied:*** Bottles of 100, 1,000.

*Trademark ® Registered Trademark for Tridihexethyl Iodide Lederle

Lederle

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

The "New" Today's Health

Today's Health, AMA's popular health magazine, is having its face lifted. In the coming months there'll be many changes in the magazine —a new logo (title line), new cover layout, tint block "news" page, broader editorial base, new editorial style and a completely new inside format. Since the AMA's Board of Trustees approved a reorganization plan for the magazine, the following changes in staff have been made: new editor James M. Liston, formerly special feature editor of *Better Homes & Gardens;* new associate editors —Dennis Orphan, previously associate editor of McGraw-Hill's *Industrial Distribution,* and William Vath, formerly managing editor of National Safety Council's *Safety News;* production coordinator Robert Hendrickson, previously with *Popular Mechanics Magazine.*

In addition, *Today's Health* now has its own advertising review committee—Leo E. Brown, AMA public relations director, chairman; Dr. Austin Smith, editor of *Journal of the AMA;* C. Joseph Stetler, director of Law Department, and W. W. Hetherington, executive publisher, *Today's Health.*

On all counts, 1957 was a good year for *Today's Health* . . . advertising lineage increased more than 30 per cent over 1956 with dollar volume showing a 40 per cent gain; 1956 advertising was renewed at a rate exceeding 90 per cent; 51 new advertising accounts were established in 1957; circulation continued to grow, topping the 400,000 mark for 9 of the 12 issues.

Aid in Battling the 1040 Form

Don't let those income tax forms get you down! Now's the time to write to the AMA Law Department for its new booklet—*The Federal Income Tax Guide for Physicians*—for answers to some of the most perplexing tax problems. This timely new booklet has been compiled from court decisions as well as rulings, regulations and publications of the Internal Revenue Service. It has been designed to give physicians a better understanding of their rights and obligations under federal income tax laws.

Conference on Perinatal Mortality

The Committee on Maternal and Child Care of the AMA's Council on Medical Service will meet March 22-23 in Chicago. The second day of this meeting will be devoted to a joint conference with North Central area physicians interested in problems concerning perinatal mortality and morbidity.

New Radio Health Series

To give your community a monthly report on the newest and best in medicine, the American Medical Association introduced its new radio transcription series—"Health Magazine of the Air." Based on current items from *Today's Health* magazine, the new 15-minute series features H. V. Kaltenborn, veteran newscaster and radio-TV commentator, and W. W. Bauer, M. D., AMA's Bureau of Health Education director. The programs are produced by the Marshall Organization, Inc., under the direction of the Bureau.

Seasonal health spot announcements—three 15-seconds; three 30-seconds and two one-minutes—will be presented on the reverse side of the platters. These spots will be given by popular movie personalities who contribute their time as a public service. The announcements will be presented in February by Peggy Wood of the "I Remember Mama" program.

First shipment of the new transcriptions have been made to approximately 400 radio stations throughout the country. The platters will be released about the fifth day of each month through December, 1958, for immediate broadcast. Although the present selection of stations has been based on those previously airing AMA radio transcriptions, local medical societies may contact the Bureau of Health Education for further information regarding additional outlets.

New TV Health Films

The American Medical Association has announced that two new 10-minute black-and-white films will be available for use on local television and for showings to school and church groups. "The Silent Killer" deals with the dangers of carbon monoxide poisonings from gasoline exhausts. "Out of Step" tells the dramatic story of an accident which occurs to a child whose father has always ridiculed safety measures, first aid and other so-called "boy scout" ideas. The Scouts, of course, come to the rescue in the end.

'DIURIL'

(CHLOROTHIAZIDE)

in

EDEMA



Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' and 'INVERSINE' are trade-marks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME

Division of MERCK & CO., Inc., Philadelphia 1, Pa.

as simple

as 1-2-3

in

HYPERTENSION

1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'



what's the most useful piece of equipment you could add, Doctor?

L-F SHORT-WAVE DIATHERMY

RIGHT FOR ANY AND ALL APPLICATIONS WHERE THERMAL THERAPY IS INDICATED

Therapeutically sound, safe, effective for every application where thermal therapy is indicated, this L-F Short-Wave Diathermy will prove more *useful* and more *productive* than almost any other piece of equipment you can name!

The L-F unit shown above successfully operates air-spaced plates, hinged treatment drum, utility applicator, etc. SEND TODAY FOR 6-PAGE BROCHURE PICTURING TYPICAL APPLICATIONS IN DAILY PRACTICE.



LIEBEL-FLARSHEIM

LIEBEL-FLARSHEIM COMPANY OS-7239
Cincinnati 15, Ohio

Please send me your 6-page brochure describing L-F Short-Wave Diathermy Units.

Name.....

Address.....

City-State.....

NEIL TRAINING SCHOOL

DELAWARE, OHIO Phone 3-2932

COUNTRY HOME AND SCHOOL

For Mentally Deficient Boys — Ages 3 to 15

Mrs. H. A. Copeland, Director



MARY POGUE SCHOOL, INC.

Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

Separate buildings for boys and girls, each with 24 hour supervision of skilled personnel. Total enrollment 90.

Catalog on request.

G. H. Marquardt, M. D.
Medical Director

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Registrar

29 GENEVA ROAD, WHEATON, ILLINOIS
(Near Chicago)

Both CENTRAL and PERIPHERAL control of cough





SYNEPHRICOL® cough syrup

ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

Combines
Central Antitussive Effect — mild, dependable
Topical Decongestion — prompt, prolonged
plus Antihistaminic and Expectorant Action

Each Teaspoonful (4 cc.) contains

Neo-Synephrine® hydrochloride	5.0 mg.
Thenfadil® hydrochloride	4.0 mg.
Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

EXEMPT NARCOTIC

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Synephrine, Neo-Synephrine (brand of phenylephrine), and Thenfadil (brand of thenyldiamine), trademarks reg. U. S. Pat. Off.

Have **YOU** *an Article in this Issue?*

The Stoneman Press will still have the type standing on the March Ohio State Medical Journal until the *15th* of the month and will furnish reprints of your article at the following prices:

	Reprint With Cover	Reprint Without Cover
100—	4 pages $20.00	4 pages $17.50
200—	" 25.00	" 20.00
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400—	" 32.50	" 26.50
500—	" 35.00	" 30.00
1000—	" 45.00	" 35.00
100—	8 pages $25.00	8 pages $18.00
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300—	" 40.00	" 26.50
400—	" 47.50	" 30.00
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Save the cost of composition by having your article reprinted by

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when anxiety and tension "erupts" in the G. I. tract...

IN DUODENAL ULCER



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of duodenal ulcer — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

Lederle

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LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Meat...

and Protein Nutrition in Vascular Disease

Whether the eventual solution of the problem of atherogenesis will come out of the field of dietetics, biophysics, or pharmacology, one fact remains undeniable:

Adequate protein nutrition is considered of importance for the age group most commonly affected by disease of the vascular system, so that the demands of good nutritional health might be met.

Meat is outstanding among protein foods. It supplies all the essential amino acids, and closely approaches the quantitative proportions needed for biosynthesis of human tissue.

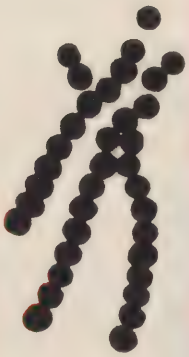
In addition, it is an excellent source of B vitamins, including B_6 and B_{12}, as well as iron, phosphorus, potassium, and magnesium.

When curtailment of fat intake is deemed indicated, meat need not always be denied the patient. Visible fat obviously should not be eaten. But the contained percentage of invisible (interstitial) fat is well within the limits of reasonable fat allowance.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

RELIEF 1 2





FROM INFECTION*

FROM IRRITATION

*as adjunctive therapy only

THE FIRST TROCHE TO PROVIDE THREEFOLD BENEFITS

'PENTAZETS'

TROCHES

NON-NARCOTIC ANTITUSSIVE EFFICACY SHOWN TO APPROXIMATE THAT OF CODEINE



AND **NOW** COUGH CONTROL TOO

With the addition of a non-narcotic antitussive to troche medication, 'PENTAZETS' provides a new and extended therapeutic advantage in this convenient form of treatment.

Treatment of the cough too, so often a troublesome symptom of sore throat, combined with wide-range antibiotic activity and soothing analgesic benefit, now offers *three*fold relief in a variety of throat irritations.

And 'PENTAZETS' are pleasant-tasting, too, making them highly acceptable, especially to children.

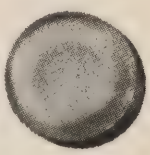
'PENTAZETS' contains:

• *Homarylamine*—a new non-narcotic antitussive with cough control shown to approximate that of codeine. • *Bacitracin-Tyrothricin-Neomycin*—a combined antibiotic treatment against many pathogenic organisms with little danger of unfavorable side effects. • *Benzocaine*—a local anesthetic for soothing relief to inflamed tissues. Being slowly absorbed, it is especially beneficial for prolonged effect and benefit to surrounding areas.

Supplied: Vials of 12.

Each 'PENTAZETS' troche contains:

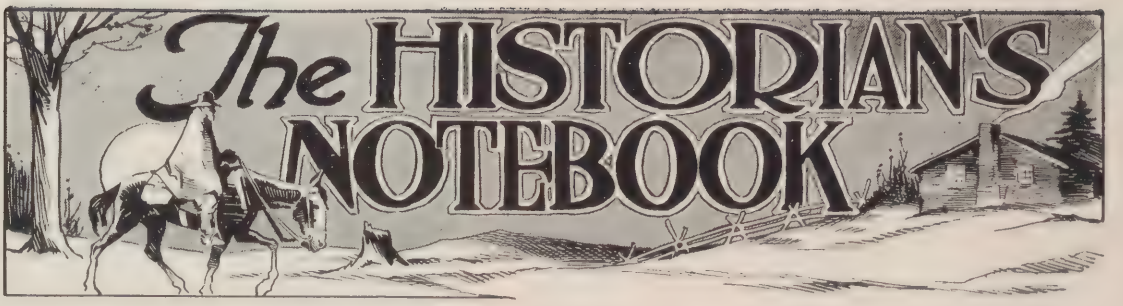
Homarylamine hydrochloride	20 mg.
Zinc Bacitracin	50 units
Tyrothricin	1 mg.
Neomycin sulfate (equivalent to 3.5 mg. neomycin base)	5 mg.
Benzocaine	5 mg.



MSD

MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.



Governor Cox and Public Health in Ohio

ROBERT G. PATERSON, Ph. D.

PART II

(Concluded from February Issue)

IN his message to the General Assembly in January, 1913, Governor Cox gave a strong presentation of the necessity for the State of Ohio to enlist its resources in the fight against tuberculosis. He followed this in February in his budget request for the $25,000. In those days this was a sizable sum. The prospects for a successful realization of our goal seemed well assured.

Then the great Ohio flood struck in March 1913! This meant that the state of Ohio had to meet the devastating emergency by an extraordinary drain upon its financial resources. In April I received a telephone message from the Governor's office. Governor Cox wished to see me! My immediate reaction was that our program had been washed away by the Ohio flood.

When I was ushered into his office, Governor Cox said he was sorry that he found himself unable to keep his promise because of the flood situation. He asked if I thought we could get along on $20,000 per annum. I replied with alacrity that I was sure we could! Again the interview was short, direct and decisive.

The flood subsided, the great emergency was met and the damage repaired. The General Assembly passed the revised budget in April, and appropriated the $20,000 per annum requested by Governor Cox.

Division of Tuberculosis, 1913

A Division of Tuberculosis was set up by the Ohio State Board of Health in May, 1913. It was the first such division in the United States. The National Tuberculosis Association, with which the Ohio Society for the Prevention of Tuberculosis was affiliated, looked upon our program with grave misgivings and tried vainly to persuade the Society's Executive Committee to abandon mixing tuberculosis work with political influences.

The Author

● **Dr. Paterson, retired and now living in Tryon, North Carolina, is Executive Secretary Emeritus 1911-1946; Director of Research 1946-1952, Ohio Tuberculosis and Health Association.**

Later, by 1917, the National Association had incorporated the idea of a division in its nationwide program.

The Division of Tuberculosis included a director, a traveling exhibit, a publicity bureau, a state supervising nurse (one of the earliest in the United States) and a publications bureau. Thus there was introduced in the organization of the Ohio State Board of Health three new avenues of approach to the public health problems of the state—a division of tuberculosis, a beginning in public health education and a state program of public health nursing.

None of these objectives could have been achieved at the time without the staunch backing of Governor Cox. He had vision and a remarkable capacity for quick and firm decisions, both needed in a successful leader in any field of endeavor.

With the rapid and sometimes radical changes in the entire structure of government that took place in the two years of Governor Cox's first term, it was not surprising that the people of Ohio could not adjust willingly to such an upheaval. Governor Cox was defeated in November 1914. He was elected again in 1916 and once again in 1918, thus becoming the first three-time Governor of the state.

In the session of the 83rd General Assembly in 1917, a bill was introduced with the consent

and active support of Governor Cox and enacted into law March 30, 1917, to overhaul the state health machinery. The 31 year old Ohio State Board of Health was abolished and in its place was created a State Department of Health consisting of a State Commissioner of Health and four members of a Public Health Council appointed by the Governor for a term of four years. The Commissioner of Health was the fifth member of the Council and was designated as Chairman. His term was fixed at five years and his appointment was by the Public Health Council, with the approval of the Governor. He could be removed for cause and only after a public hearing. This law marked the beginning of what we are pleased today to call the modern public health program in Ohio.

Governor Cox was much interested in this piece of legislation and exerted his influence especially in expediting the bill through the General Assembly. His appointments to the first Public Health Council[9] were excellent and brought back into the work Dr. Charles O. Probst as a valued member of the Council who continued to serve until his death in 1933.

It had been recognized from the establishment of the Ohio State Board of Health in 1886 that the weak link in the health organization program in Ohio was in the local area. Attempts to strengthen the local health pattern had been attempted from time to time in the General Assembly but to no avail. Then the devastating epidemic of influenza swept through the United States in 1918-19. Ohio in World War I, was aware of the havoc wrought by the epidemic among the troops concentrated in military camps and among the civilian population of the state.

In Ohio the township and village, and most of the municipal boards of health collapsed completely in the face of this vast emergency. In November 1918 Governor Cox was re-elected for his third term as chief magistrate of the state. He was quick to sense the need for a reorganization of the local health machinery. A bill was introduced in the General Assembly written by the public health leaders of the state that provided for the first comprehensive law relating to local health organization in Ohio. It was known as the Hughes bill and was passed April 17, 1919, and approved by Governor Cox on May 9, 1919. It was to go into operation January, 1920.

If this law had remained intact Ohio would have had a health organization at least 25 years in advance of every state in the nation. A collateral decision by the Ohio Supreme Court held a law unconstitutional because it attempted to classify cities. This decision affected the Hughes law. So on December 19, 1919, the General Assembly enacted the Griswold amendment to make the Hughes law conform to the Ohio Supreme Court decision.[10] The law became effective January 1, 1920. Incidentally, the Ohio Society for the Prevention of Tuberculosis provided $1,000 for attorney's fees to appear in the original Cleveland case on which the Ohio Supreme Court ruled.

The Hughes-Griswold law reorganized municipal health departments in cities of 5,000 population or over; and established general health districts in each county of the state outside of cities. It provided for the employment of health commissioners on a part-time or full-time basis; it provided for the first time for public health nurses as an integral part of health administration; and created a state subsidy of one-half the annual local payroll, up to $4,000 per annum. The Hughes-Griswold law reduced the number of local boards of health from 2141 to 168 health districts in the state—80 city districts and 88 general districts.

Governor Cox was intensely interested in this piece of legislation since his basic goal was for efficient administration. He gave constant advice upon the strategy required to secure the enactment of the law.

Cox Decisive in Health Legislation

It is now evident that in the three terms served by Governor Cox he had a decisive hand in the creation of the present day public health organization, in Ohio, viz., in 1913 the tuberculosis appropriation; in 1917 the reorganization of the Ohio Department of Health; and in 1919-20 the complete overhaul of the local health machinery of the state.

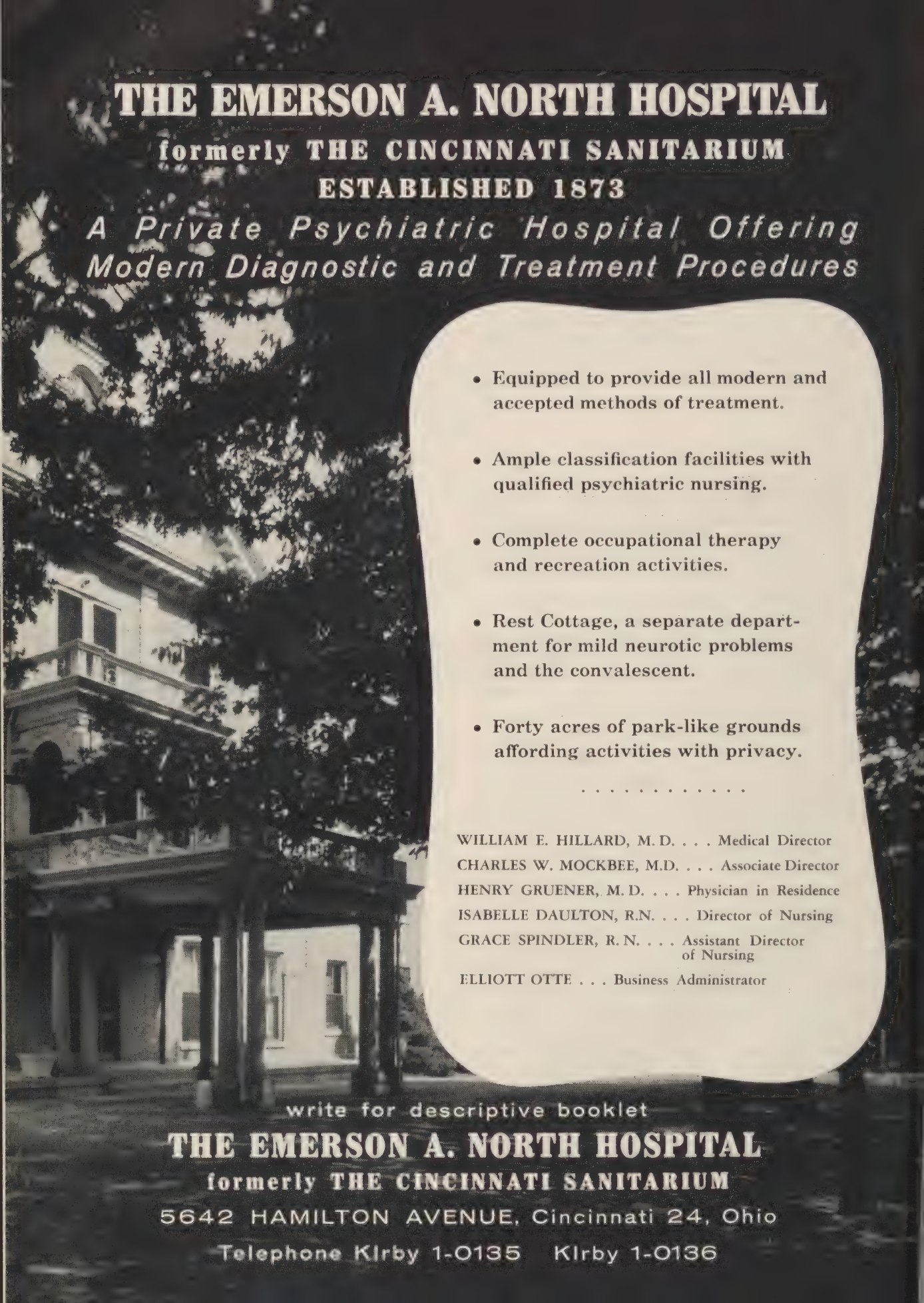
Tuberculosis and public health workers in Ohio thus have good reason to owe a great debt of gratitude to the Honorable James W. Cox for his intelligent and sympathetic interest in providing the state with the means to carry forward a program to combat unnecessary illness and premature death.

In retrospect, it always seemed to the author a curious irony of fate that pitted two Ohio leaders against each other in the 1920 presidential campaign,—Harding versus Cox. Both were newspaper publishers as well as prominent political leaders. Harding defeated Cox largely on the League of Nations issue. In the light of subsequent events, it is interesting to speculate what the course of history would have been had Cox defeated Harding.

References

9. Charles O. Probst, M. D., Columbus, until July 1, 1918; W. I. Jones, D. D. S., Columbus, until July 1, 1919; R. M. Calfee, Cleveland, until July 1, 1920; G. D. Lummis, M. D., Middletown, until July 1, 1921.

10. Laws of Ohio 1919, Vol. 108, part 1, p. 236; part 2, p. 1020.



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News from the Nation's Capital of Interest to Physicians: Developments in Medical and Health Fields

Veterans Administration plans to spend between $16.9-million and $23-million on nine hospital improvement or expansion projects, including the Chillicothe, Ohio, VA hospital.

* * *

A special committee has recommended to Defense Administrator Gray that producers and distributors of medical, pharmaceutical and hospital equipment should be encouraged to maintain larger inventories in dispersed locations in the interest of national defense and survival under possible enemy attack.

* * *

U. S. and Russia in 1958 will (1) exchange teams of medical scientists to lecture and discuss experiences, (2) exchange medical publications and (3) exchange medical films. Recently completed agreement was hailed as "a significant first step in the improvement of mutual understanding between the peoples of the United States and the Union of Soviet Socialist Republics."

* * *

Army has issued directive whereby medical and dental officers currently serving voluntary or involuntary two-year tour of duty and scheduled for discharge before August 1 may apply for immediate discharge, provided they have served 21 months. The Navy issued a similar directive last summer.

* * *

Atomic Energy Commission report shows 1,900 private practitioners and medical institutions licensed to use radioisotopes, compared with 748 in 1954. The report noted rapid increase in Cobalt 60 teletherapy, with more than 150 installed sources of the radioisotope throughout U. S.

* * *

More than 12,000 invitations have been sent out for the President's Conference on Occupational Safety March 25-27. This conference encompasses many medical subjects, including such topics as radiation hazards, safety motivation and responsibilities of medicine and nursing in prevention of occupational accidents and diseases.

* * *

Study is under way by Federal task force involving sweeping survey of nation's health facilities. This involves taking inventory of hospitals, clinics, convalescent homes and other health institutions, and reaching conclusions as to their optimal use for defense mobilization purposes.

* * *

Citizens Committee for the Hoover Report is currently concentrating on five major administrative reforms, one involving government's widely dispersed health and medical services. Plan would be to create a Federal Advisory Council of Health possessing controls over health care for veterans, aid to states for hospital construction, training and utilization of medical personnel, and coordination of Federal and private health resources.

* * *

Senator Morse (D., Oreg.), defending himself against "silly" and "intemperate" charges brought by National Society for Medical Research prompted by Morse's insertion of lengthy antivivesectionist's propaganda into the Congressional Record last year, has inserted into the record 21 columns of data rebutting the antivivisectionist's horror stories.

* * *

Health, Education and Welfare Secretary Folsom recently reported that Social Security beneficiaries have risen to more than 11-million (compared with 9.3-million at beginning of 1957), and that 150,000 disabled workers 50 to 65 years of age received $60-million in payments, this program requiring $5-million in expenses.

* * *

Joint report of Departments of Labor and Commerce shows construction of private hospitals continued to gain while new starts in construction of public hospitals and institutions decreased in recent months.

* * *

Informal group of physicians who formed a committee last fall at the encouragement of Vice-President Nixon and several Senators have issued a statement calling for powerful development of behavioral science—the "sciences of man" — to bolster defense, secure the peace and strengthen the U. S. in many ways. Report called for more public and private funds to speed research into human motivations and related fields.

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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 54 March, 1958 No. 3

JONATHAN FORMAN, M. D., *Editor*

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The Diagnosis and Treatment of Intracranial Aneurysms

H. T. GLASER, M. D.

THIS is to report on a group of patients usually seen for the first time at home by a physician or who, in some localities, may be seen first in a hospital emergency room.

Generally, the symptoms appear suddenly in a patient who apparently has been quite well. He may have bent over to tie a shoestring; he may have bent over or made some other relatively minor effort while working in his yard at home or at his work, when he suddenly experienced severe headache often frontal at first, but within a short time spreading to the back of the head, the neck and shoulders. Usually the headache is described as throbbing and unbearable.

Changes of consciousness may occur which range anywhere from drowsiness to coma. A convulsion is not unusual at some stage of the illness and one usually finds the neck stiff within a few hours of the onset.

Seeing the patient for the first time one would necessarily consider coma due to diabetes, nephritis, or to head trauma, but with a short history and a few routine tests these can be ruled out quickly. One would then give rather concentrated thought to pathology of the central nervous system as the source of the patient's difficulty.

A most important procedure in view of what the physician now knows would be a lumbar puncture and on finding fresh blood well mixed with cerebrospinal fluid, he would conclude the patient's difficulty is due to subarachnoid hemorrhage.

The Author

● **Dr. Glaser, Zanesville, Ohio, formerly Resident in Neurosurgery, Buffalo General Hospital; assistant in Neuroanatomy and Neurosurgery, University of Buffalo College of Medicine, Buffalo, N. Y.**

The change of consciousness could be dependent on the rate and duration of bleeding. Nuchal rigidity may be caused by any inflammatory involvement of the meninges, but in the case of an atraumatic bloody lumbar tap, it probably is secondary to foreign material in the subarachnoid space, in this case free blood acting as the irritant. Blood in the subarachnoid space particularly affects the neck extensor musculature and flexion may be impossible while hyperextension can be readily carried out. Convulsive activity can be explained by increasing intracranial pressure particularly as this might irritate the motor strip.

The progress of the patient depends on the rapidity and amount of bleeding and he may die in a few hours or days. It is estimated that 50 per cent of patients with subarachnoid hemorrhage

die in the first attack. In the survivors the signs and symptoms recede and in some never to recur. In others, the second, third or subsequent attack may kill. I have seen one middle-aged woman come into the hospital in coma and after a lumbar tap and two or three days' time improve gradually, undergo angiography in which an aneurysm was demonstrated after the first hemorrhage, only to die suddenly in the fourth bleeding episode before surgery could be undertaken. This was prior to the use of hypothermia as a surgical adjunct.

Medical Management

The immediate medical treatment, in addition to nursing care, consists of total bed rest, which means the patient must make no straining effort whatsoever. He should be turned and fed. The head of the bed may be elevated, but the patient should not raise himself. The bowel should be kept in such condition that he need not strain. Lumbar taps are carefully repeated for slow reduction of the increased intracranial pressure. Any required sedative should be used.

Up to this time there may have been very little evidence from the examination for either lateralization or localization of the lesion causing the subarachnoid hemorrhage. However, in some cases, there may be localizing signs. A complete third nerve palsy without other findings suggests an aneurysm lying against that structure; a ruptured anterior cerebral artery aneurysm may produce weakness of a foot or a leg, or a middle cerebral artery aneurysm, particularly if it bleeds into the brain substance as well as subarachnoid, may produce hemiparesis.

To determine the underlying cause of the subarachnoid hemorrhage, whether vascular malformation or aneurysm, angiography should be carried out as soon as the patient's condition permits. This means when the hemorrhage has ceased and the patient appears to be improving from his initial insult. This ordinarily may be two, three or four days later, but in some clinics it may be done at once, particularly if operation is to follow immediately under hypothermia. The entire purpose of hypothermia is to enable the surgeon, relatively safely, to make a definitive operation on the aneurysm much earlier than otherwise and before the lesion has the opportunity to bleed the second time.

Angiography may be performed under general anesthesia in the Radiology Department. It consists essentially of rapid percutaneous injection of Diodrast® and more recently Hypaque® into specific arteries in the neck. We prefer pure internal, pure external or vertebral injections. X-rays of the head, anteroposterior and lateral, are made to obtain arterial and venous phases of the contrast material in the cerebral vessels.

In 10 to 20 per cent of patients exhibiting subarachnoid hemorrhage, angiography does not reveal the cause of the hemorrhage and these people have a better prognosis than those in which an aneurysm is the etiologic lesion. Some of these patients, however, do die from subsequent bleeding. They are kept in bed six to eight weeks in the hospital before dismissal to their referring physician.

Dunsmore and Polycyn[1] reported on a follow-up study of 151 patients, in 81 of whom no aneurysm was demonstrated on angiography. All but six had angiography. Follow-up reports on 71 of the 81 patients are available and 52 were alive and doing reasonably well from 1 to 10 years after examination. Nineteen died and all but one of the deaths occurred within one year of the original hemorrhage. All deaths except one (hypernephroma) were due to subsequent hemorrhage. This makes a mortality rate of about 27

TABLE 1.—*Results of management of 81 Patients with angiographically demonstrated Intracranial Aneurysms.*

				Deaths			
Total Number Patients Seen	81			28 (30%)			
Untreated Patients (various reasons)	23			16 (70%)			
Treated Patients	58			12 (20%)			
1. **Cervical ligation only**		12			3 (25%)		
Subclinoid carotid			1			0	
Supraclinoid			11			3 (27%)	
2. **Trapped**		21			5 (24%)		
With cervical ligation			11			2 (18%)	
Subclinoid Carotid				1			0
Supraclinoid				10			2
Intracranial only			10			3 (30%)	
Supraclinoid Carotid				4			0
Carotid Bifurcation				1			0
Anterior Cerebral				3			2
Anterior communication				2			1
3. **Occlusion of Aneurysm**		24			4 (16.6%)		
Supraclinoid			15			2 (13%)	
Carotid bifurcation			5			1	
Ant. cerebral			2			0	
Ant. communicating			2			0	
Middle cerebral			2			1	
4. **Reinforcement only**		1	1		0		
		58	58		12	12	

per cent. Gardner[2] reported 50 per cent mortality rate in his series of subarachnoid hemorrhage and he stated that if the patient had a second attack, the odds were nearly three to one he would die. It appears that if the patient with subarachnoid hemorrhage, but without an aneurysm survives one year, the outlook for life thereafter is excellent.

Surgical Management

The surgical management of intracranial aneurysms has in the past few years proved superior in results to the general medical management. This has resulted from improved diagnostic ability to separate by angiography those patients having aneurysms from those who have not. We are now in the stage of determining the best means of treating the former.

Proximal Ligation

The basic principle employed earliest in the control of hemorrhage and later for aneurysms was that of proximal ligation of the affected artery. In the case of intracranial aneurysm this meant carotid ligation in the neck, common or internal. Carotid ligation is relatively simple and can be done under local anesthesia without lowering the patient's blood pressure. This is important in treating all forms of intracranial vascular disease and it controls bleeding aneurysms in a good percentage of patients. It does have certain disadvantages. (1) It deprives the brain of blood through one of its major vessels and unless there is adequate circulation from the opposite side, hemiplegia results. (2) The aneurysm is still patent and may bleed again. (3) Co-existing aneurysms on the opposite side would be exposed to additional stress by the compensating blood flow from the opposite carotid circulation.

Presently we have a patient under observation with bilateral intracranical aneurysms (demonstrated by angiography), one of which has bled the second time. Should the patient ever become operable, it appears theoretically more sound to operate each aneurysm than to ligate two carotids. There are references in the literature of cases where both carotids have been ligated apparently successfully, particularly in patients with carotid-cavernous sinus fistula. This lesion, however, is quite different than intracranial aneurysm.

TABLE 2.—*Location of Aneurysms in This Series of 81 Patients.*

	Treated		Untreated		
	Total	Died	Total	Died	Total
Subclinoid Carotid	2	0	1	1(100%)	3
Supraclinoid Carotid	40	7(17%)	2	1(50%)	42
Carotid bifurcation	4	1(25%)	—	—	4
Anterior cerebral	5	2(40%)	3(40%)	3(100%)	8
Anterior communicating	4	2(50%)	9	7(78%)	13
Middle cerebral	3	1(33%)	8	3(50%)	11
Multiple	—	—	2	1(50%)	2
	58	13(22.4%)	23	16(70%)	81

Intracranial Attack

Intracranial attack on the aneurysm itself has the purpose of eradicating the lesion while preserving the vascular pattern of the brain. From the data to follow, it appears to be the best approach, although it involves craniotomy and is dangerous. It permits closure of the aneurysm in a certain percentage of cases. Only by exposing the lesion and dissecting it fully, can one determine whether or not the aneurysm is amenable to this treatment.

In carrying out the attack on the aneurysm itself, we have been employing temporary ipsilateral total carotid occlusion in the neck with a Blaloch-Poppen clamp for periods up to 24 hours before craniotomy. This gives some insight as to whether the opposite carotid circulation is adequate should an intracranial "trapping" procedure become necessary at the proposed craniotomy.

It has been pointed out by Dandy[3] that smaller vessels are less prone to thrombosis than larger ones. By direct attack on the aneurysm intracranially, it is hoped that no major vessel need be closed, but only the aneurysmal neck. If one finds

TABLE 3.—*Present Status of Patients with Surgically Treated Aneurysms.*

	Carotid Ligation	Trapping Operations	Occlusion Aneurysm Neck	Reinforcement	Total
Total number of cases	12	21	24	1	58
Surgical fatality	3(25%)	5(24%)	4(16.6%)	—	12(20%)
Survivors	9	16	20	1	46
Status unknown	1				1
Early postoperative status		2	4		6
Well	2	5	9		16
Working, with mild neurologic deficits	3	6	3		12
Considerable neurologic deficit	1	2	3	1	7
Invalid	...	1	1		2
Subsequent death	1 (hemorrhage 1 (unrelated)	1 (unrelated)			3

at craniotomy after complete dissection and exposure of an aneurysm that this is not possible and a clip on a major vessel or branch of a major vessel becomes necessary, it may be possible that we create a smaller infarct.

Two other recent advances have encouraged intracranial attack on the aneurysm itself. These are: (1) hypotensive drugs which have made possible safe reductions of blood pressure during the actual dissection and handling of the aneurysm. (2) hypothermia which allows a reduced total brain blood flow without injury to nerve cells. Botterell[4] of Toronto has shown that with a body temperature of 82 degrees (F), the anterior and posterior cerebral circulations bilaterally may be closed completely for 11 to 12 minutes without ill effect.

The hazards of intracranial approach include: (1) General anesthesia which in itself carries some degree of danger, as compared to local anesthesia used for cervical carotid ligation. (2) Craniotomy per se carries some degree of risk. (3) In some cases after craniotomy has been done and the aneurysm dissected, it is found the neck of the aneurysm is unsuitable for ligation or "clipping." It then becomes necessary to "trap" the aneurysm by occluding the parent vessel on each side of the lesion. The success of this procedure depends upon an adequate collateral circulation, but so does ligation in the neck. Inasmuch as intracranial ligation would involve a smaller vessel, the danger of any thrombosis and resulting infarct, theoretically, should be less.

In Buffalo General Hospital angiography is performed as soon as the patient's condition permits in all cases with subarachnoid hemorrhage. In those cases in which an aneurysm is localized, craniotomy is done (under hypotension) before the third week post-hemorrhage. Under hypothermia it may be done earlier if necessary. Because of a recent fatality which may be attributed to the use of hypothermia, the latter has not as yet become routine, having been used on seven occasions. An attempt is made to close the aneurysmal neck by ligation or clip. If the lesion is not closable it is "trapped" by clips on the parent artery proximal and distal to the lesion, but this procedure is not the one of choice and it has become necessary less often.

The time of surgical intervention is important. Operation in the first week after hemorrhage on eight patients resulted in five deaths, a mortality rate of 62 per cent; in the second week two of seven patients died with a mortality rate of 28.5 per cent; in the third week two of 13 patients died with a mortality rate of 20 per cent; after the fourth week two of 17 patients died with a mortality rate of 11.4 per cent. For operations done after the second week the mortality rate averaged 14.3 per cent. While it is safer to operate upon patients after the second week, it is not safe to allow them to wait so long because fatal recurrences are common in the first two weeks. This emphasizes the necessity of seeking measures that permit earlier safe operations.

Table 1 shows the results of management of 81 patients with angiographically demonstrated aneurysms in Buffalo General Hospital, 58 of whom were treated surgically and with a 20 per cent mortality rate. Twenty-three were not treated surgically and with a 70 per cent mortality rate. In our earlier experience 12 were treated by cervical ligation with a 25 per cent mortality rate. Twenty-four had direct attacks on the aneurysm with a 16 per cent mortality rate. Twenty-one had "trapping" procedures with a 24 per cent mortality rate. CONCLUSION: "Trapping" procedures are as safe as cervical carotid ligation and occluding the aneurysm intracranically proved safer than either.

It is realized that the total number of cases in this series is small and the results in a large series may change the percentages, but they are offered as an indication of what might be expected from presently available methods of treatment.

Summary

Our experience in Buffalo General Hospital is:

1. Patients having angiographically demonstrated aneurysms have been treated surgically more safely than otherwise.

2. Occlusion of aneurysmal neck where possible, thus preserving the vascular pattern, is the treatment of choice. Other methods have been forced retreats.

3. Time of operation after hemorrhage is a crucial factor in survival.

4. Methods designed to allow safe operation earlier than the third week and thus prevent hemorrhagic recurrences are being investigated.

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Climatologic Factors

The demand for electrocardiograms in a northern New England community shows a definite maximum in April and a minimum in July. This incidence is similar to that previously found for coronary occlusion and acute heart failure, except that the maximum occurs later. This peculiarity is explained by local climatologic factors.—E. Lepeschkin, M. D., *J. Maine M. A.*, 49:8, Jan., 1958.

Hospitalization of the Tuberculous—Home Versus Hospital

J. B. STOCKLEN, M. D.

Historical Background Of Rest Treatment

BODINGTON in England in the nineteenth century first advocated graduated exercise, good diet and fresh air as valuable in the treatment of tuberculosis. For 2,000 years prior to this countless nostrums had been used in treating the disease.

In 1854 Brehmer established an institution for the treatment of tuberculosis in Germany. He advocated exercise as a treatment of tuberculosis because the hearts of autopsied tuberculous patients were small and he reasoned that "strengthening" of the heart by exercise was indicated. Dettweiler, a patient of Brehmer's, however, decided that he felt better when he rested. He established a sanatorium at Falkenstein with rest as the basic principle of treatment. Trudeau discovered that he had tuberculosis and went to the Adirondacks to spend his last days in surroundings that he loved. He there discovered that he improved when he rested. He lived an active life for many years although he eventually died of tuberculosis. He founded Trudeau Sanatorium in 1885, the first institution in the United States devoted to the care and treatment of tuberculosis. *Rest became the basic treatment for the disease.* It has a background of more than 70 years in this country.

Advent of the Antimicrobials

There was little dispute with this basic tenet until the advent of the antimicrobials for the tuberculous. The effect of these chemotherapeutic agents was so striking that immediately the problem began to arise as to whether bed rest was necessary in the treatment of tuberculosis.

A number of investigators have reported on five years of experience with outpatient care of the tuberculous.

Experiences with Outpatient Treatment

In 1952 McCollough reported that of 205 outpatients with active tuberculosis treated with pneumoperitoneum (only two of the patients had antimicrobials) 61 did not require hospitalization and the disease was considered to be inactive or arrested at the end of the observation period.

This article was prepared in corroboration with the Publications Committee of the Ohio Trudeau Society, medical section of the Ohio Tuberculosis and Health Association.

The Author

● **Dr. Stocklen, Cleveland, is Controller of Tuberculosis for Cuyahoga County.**

Of 348 outpatients treated with anti-tuberculosis drugs by Robins and his associates 39 per cent improved radiologically, and of 222 patients with positive sputum only 99 had converted to negative at the end of six months.

Tyrrell reported a series of cases with active tuberculosis in which alternate patients were treated as ambulant patients and the others as inpatients. All patients received isoniazid and streptomycin. The inpatients showed slightly better results in respect to cavity closure, 64.5 per cent as compared to 45.4 per cent. At the end of six months 22.2 per cent of the inpatients and 19.5 per cent of the outpatients had positive sputum examinations.

Kennedy in Scotland reported that of 129 patients selected at random and treated at home or in the hospital with antimicrobials the results of treatment were the same in both groups.

Kay in Edinburgh compared the treatment of a group of active but not infectious cases of tuberculosis treated in the hospital and a similar group which was treated and permitted to work. The results were the same in each group.

This author reported on 163 patients with active tuberculosis treated with streptomycin and PAS as outpatients. Ninety-six finally required hospitalization and 67 did not.

Disadvantages of Outpatient Treatment

It is apparent from these reports that tuberculosis can be treated successfully on an outpatient basis *in some instances.* Unfortunately it is not possible to predetermine which patients will do well on an outpatient regimen and which will not.

Not considered in the foregoing reports are two major problems:

(1) When patients with active tuberculosis are kept at home many associates become infected. This negates the essential principle of patient isolation in tuberculosis control.

(2) Patients who do poorly during home care

frequently have disastrous worsening of disease and may lose their chances for recovery.

Statement of the Ohio Trudeau Society

It is true that the tuberculous patient can rest at home but it is a fact that the vast majority do not take as much bed rest at home as they would get in a hospital. Until the advocates of outpatient treatment have more evidence that has stood the test of time it would seem wise to adopt a conservative course and follow the current recommendations of the Ohio Trudeau Society:

"I. Hospitalization is very strongly recommended for all patients who have active tuberculosis. Even beyond this, each patient should be convinced that hospitalization benefits him medically and the community public health wise. New techniques and even ardor are needed by every physician who sees tuberculosis patients in order to learn how to convince the patient of these benefits. Whenever a patient's refusal or reluctance to accept hospitalization reflects objective shortcomings in hospital, health, and welfare services, the community should be aroused to do something about these inadequacies.

"II. Only after all efforts to hospitalize have failed should the patient with active tuberculosis be treated by a private physician or if necessary by a public clinic. It has been indicated that even after two years of outpatient treatment, 40 per cent of treated patients still have positive sputum.

"When treatment on an outpatient basis is necessary, the patient, if he has infectious tuberculosis, must cooperate in preventive public health measures as outlined by the health commissioner.

"III. If the patient does not cooperate in protecting others as recommended by the health commissioner, enforced isolation should be carried out.

"We believe these three recommendations should be given the widest possible interpretation among professional groups concerned with tuberculosis control."

Treatment of the Prediabetic Woman And Her Infant

The treatment of the woman with prediabetes and of her infant is similar to that of patients with diabetes mellitus. If the metabolic disorder is mild and no complications develop pregnancy can usually be allowed to continue to term. Early delivery is advisable for those with more advanced prediabetes or in those in whom toxemia or polyhydramnios develop.

Cesarean section should be performed only for obstetric complication.—J. Robert Williams, M. D., Philadelphia: *J. Arkansas M. Soc.,* 54:312, January, 1958.

Selective Readings . . .

The Physician-Writer's Book—Tricks of the Trade of Medical Writing, by Richard M. Hewitt, A. M., M. D., Senior Consultant, Section of Publications, the Mayo Clinic; Associate Professor of Medical Literature, the Mayo Foundation, Graduate School, University of Minnesota, 415 pages, with about 40 figures and several tables. (*$9.00. W. B. Saunders Co., Philadelphia 5, Pa.)* If there is any physician in America who has had the experience and who is capable of producing a book on medical writing, it is the author of this splendid text. Dr. Hewitt has spent his professional life in medical writing and editing. He has had ideal preparation for such a task for he was formerly a high school teacher of English and was assistant editor of *The Journal of the American Medical Association* for three years, under the editorship of Dr. Morris Fishbein.

Every physician who even occasionally writes an article should have this book. Experienced medical authors, medical editors, and the large group of nonmedical personnel engaged in various phases of medical communications will derive much benefit from the text. It is unquestionably one of the best books in this special field in which few texts have been written. Dr. Hewitt is a Past-President of the American Medical Writers' Association and is Chairman of the Association's Educational Committee.

The Habit of Tobacco Smoking, by W. Koskowski, M. D. (*$5.00. Staples Press, Ltd., London,* United States distributor, *John de Graff, Inc., 31 East 10th Street, New York 3, N. Y.)* During the 460 years since the discovery of tobacco by the white man this magic plant has played an important part in the history of civilized society. It has been considered a panacea for all ailments and maladies. It was believed for a long time to have had a mysterious influence on the minds. Not only has it been of great significance in the economic life of mankind, but it has also played an important role in the psychological, social, and biological development of human society.

Throughout, tobacco has also had its opponents. Current medical research has found a relationship existing between the incidence of certain disease and the smoking of tobacco. The author of this work attempts to discuss the tobacco habit objectively both from the historical and the medical current controversy about the extent of this relationship. This book provides a handy and authoritative reference.

Bilateral Avulsion of Quadriceps Tendon—Case Report

MILLARD C. BEYER, M. D.

A COLORED male patient, age 52, was seen on October 7, 1956, with an injury to his left leg following a minor automobile accident in which he collided with a utility pole. He stated that his left knee hit the dashboard of the car and he felt something snap; also that he felt a sudden pain in the region of his left knee at the time of impact with the pole.

The patient was admitted to City Hospital and on examination there was a definite depression just above the patella. The patella was in the usual position but was freely movable and there was present a moderate hemoarthrosis of the left knee. Roentgenograms taken at the time of admission to the hospital, in the anteroposterior, lateral, tunnel and tangential projections revealed nothing unusual except a mild osteo-arthritis.

Operation

On October 13, 1956, the knee was explored and it was found that the quadriceps tendon had been avulsed from the superior portion of the patella leaving practically no fragments of the quadriceps tendon attached to the patella. The laceration extended laterally. Prior to the operation the patient was not able to extend the left knee. A drill hole was passed transversely through the patella in the upper portion and a small wire was passed through the drill hole and then through the quadriceps tendon and the tendon was brought down to the patella and held there by means of the wire suture. Additional sutures of black silk were used to close the lateral expansions and the transverse incision of the skin was then closed. A circular plaster splint was applied from the ankle to high in the thigh.

On November 6, 1956, the plaster splint was removed and active and passive exercises were started. The patient on November 26, 1956, was weight bearing, doing quite well and was ready to return to work.

The Second Accident

On November 30, 1956, while getting out of his car, his foot slipped and he felt a sudden sharp pain in the region of his right knee. He was admitted to Akron General Hospital and the clinical findings were the same as for the left knee. On December 4, 1956, he was taken to surgery and through a transverse incision the same findings were present as in the other knee and the same procedure was done as on the left knee. No plaster splint was applied this time, a compression bandage was applied postoperatively and the patient was allowed to walk. On January 18, 1957, there was no atrophy of either quadriceps and the patient returned to work on February 19, 1957.

A section of the tendon was submitted to the laboratory for microscopic examination and it was found to be composed of dense white hyaline fibrous connective tissue with a tendency to increased vascularity and a fairly diffuse mononuclear inflammatory infiltrate was present.

Discussion

Watson-Jones states that bilateral avulsion of the quadriceps tendon is not uncommon. The clinical findings parallel the findings of the case in discussion. He further states that if the tendon is not repaired ossification of the hematoma usually develops. He recommends a longitudinal incision and also recommends suturing through the portion of the tendon that is attached to the patella. In the case presented there was no tendon to suture to. Watson-Jones does not feel that external fixation is necessary.

K. T. James reported a case of bilateral avulsion of the quadriceps tendon in a patient 66 years old. In the case he describes, the patient had fallen down the stairs and the second avulsion occurred when he was hopping across a landing to get help and the other side gave way. The repair in his case was done with kangaroo tendon. He states that the same mechanism is present to produce the injury as to produce a transverse fracture of the patella by indirect force and he feels that the incidence of the injury is extremely low.

Summary

A case of bilateral avulsion of the quadriceps tendon with an interval of approximately eight weeks between the two injuries.

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The Author

● **Dr. Beyer, Akron, is a member of the Orthopedic Staff, Akron City Hospital.**

Ironer Burns of the Child's Hand

A Problem in Accident Prevention

PHILIP A. WEISMAN, M.D.

THE purpose of this report is to call attention to the burn produced by the household electric ironer or mangle and to suggest measures to treat and to prevent this tragic injury of childhood.

Although the automatic ironer has been available to the public for over 35 years, few writers have described the ironer burn and its very typical characteristics[1,2,3,4]. Since January 1, 1954, four children with ironer burns of the hand have been admitted to Dayton hospitals. A fifth patient with deformities secondary to his childhood ironer burn has been seen in consultation.

Clinical Findings

The circumstances of the accidents and the clinical findings have been strikingly similar. The children were between 15 months and four years of age. The mother momentarily left the room in which she was ironing. The child investigated the ironer and pushed the starting button. The rotating cloth covered rollers drew the other hand into the machine. With the hand trapped and the hot metal shoe resting against the dorsum, the flesh was deeply burned before the mother could release the hand (Fig. 1).

In all cases the back of the hand suffered a full thickness burn of the skin while the palm escaped injury (Fig. 2). In three patients extensor tendons were exposed by the burn. Nail beds were badly damaged in four of the cases. In two of the patients finger joints were involved, and in three the dorsum of the wrist and forearm was burned. In all instances the thumb and thumb web space escaped serious injury.

Treatment

Excellent references to the treatment of thermal burns of the dorsum of the hand are listed in the bibliography[5,6,7,8,9], and it is not our purpose to review this subject. However, some observations concerning our experiences with three of the acute burns may be helpful to others who care for these injuries.

The children were referred for reconstructive surgery between two and four weeks after their accident. Definitive surgery could have been accomplished earlier and convalescence shortened had the transfer been more prompt.

From the Plastic Surgical Services of Good Samaritan, Miami Valley, and St. Elizabeth Hospitals, Dayton, Ohio.

The Author

● **Dr. Weisman, Dayton, is a member of the staffs, Department of Plastic and Reconstructive Surgery, at Good Samaritan, Miami Valley, and St. Elizabeth Hospitals; consultant, plastic and reconstructive surgery, Wright-Patterson AFB Hospital, and Brown VA Hospital.**

Utilizing local skin flaps and split thickness skin grafts it was possible in all cases to obtain early healing (Fig. 3-a) and good grasp function (3-b) with a single surgical procedure. The operations were meticulous and time consuming, requiring from three to five hours. However, the children were in good condition, and with tourniquet ischemia there was minimal loss of blood.

In each instance granulation tissue was debrided away, down to normal tissue. The eventual softness and pliability of the skin-grafted areas is attributed to this maneuver.

In none of our patients was there any doubt concerning the full thickness depth of the burn. However, since even deep second degree burns of the dorsum of the hand are prone to scar contracture in extension, one should not hesitate to excise questionably viable skin at the time of early grafting.

Grafts were removed from the thigh with a dermatome calibrated to thicknesses of .009 to .011 inches. In these young children this thickness of skin produced a good functional surface for the dorsum of the hand.

In one patient the junction of graft and normal skin fell along the dorsal lateral aspect of two of the fingers. Linear extension contractures would have occurred in these areas were they united as they lay. Accordingly, an immediate Z-plasty was done between skin graft and normal skin at the initial skin-grafting operation. Soft scar without contracture resulted (Fig. 3-a).

In three patients tendon was bared and in one an interphalangeal joint was open. Nevertheless these areas were grafted successfully with split

skin. Soft tissues were drawn together over the exposed joint with a buried catgut suture.

A bulky tie-on pressure dressing was applied to the hands and the fingers were immobilized on volar plaster of paris splints in semiflexion. No splinting was continued beyond the 15th to 19th days, although in one patient some intermittent elastic traction was applied for a few weeks thereafter to mobilize the fingers in flexion. All patients had good return of flexion. No extension contractures of the metacarpal-phalangeal joints have occurred.

Two of the three children were permitted to return home between initial surgery and the change of dressing under anesthesia at one week. All dressings were discontinued between the 15th and 19th days, after which the hands were washed daily by the parents and protected with white stockings for another week.

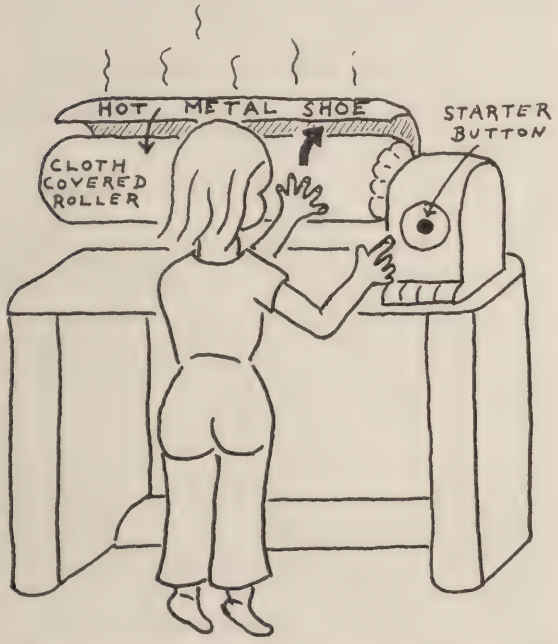


FIG. 1. Mechanism of Ironer Burn: When the child presses the starter button the roller turns. The hand resting on the roller is drawn into the ironer. The hot metal shoe comes down on the dorsum of the hand, which is trapped and burned.

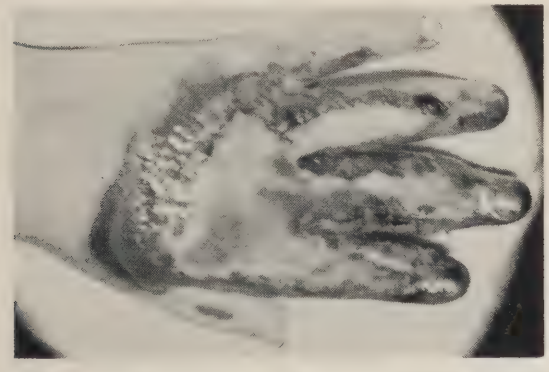


FIG. 2. Case 1. C. R. Age 27 months. Ironer burn of left hand with full thickness destruction of skin, injury to nail beds, and eventual exposure of some tendons and joints. Photograph 28 days after burn shows unseparated eschar.

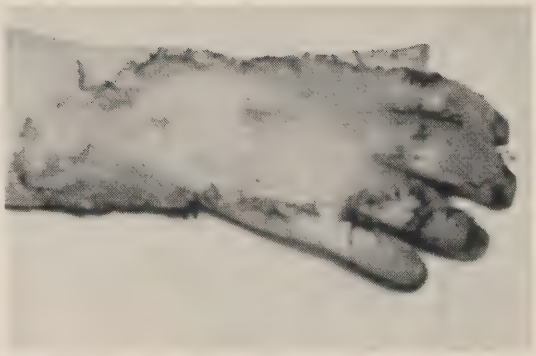


FIG. 3-a. Case 2. T. M. Age 17 months. Ironer burn of right arm and hand with destruction of skin, nail bed injury, and exposure of extensor tendon of long finger. Fitted split thickness skin graft applied 19 days after burn. Photograph 8 days after operation shows complete take of graft. "Z-plasties" between graft and unburned skin of ring and index fingers were done to prevent dorsal linear scar contractures.



FIG. 3-b. Case 2. Photograph two years after primary repair shows child's ability to make a normal fist. Note web formation between bases of fingers.

A shortcoming of the repairs from the esthetic standpoint has been web formation in the interdigital spaces (Fig. 3-b). The webs have occurred because the skin grafts were not sufficiently large to permit resurfacing both the dorsum of the fingers, portions of the lateral aspects of the fingers, and the web spaces with one piece of skin. It is suggested that web formation might be avoided by utilizing one skin graft to resurface the dorsum of the hand itself and also the web spaces, and additional grafts to resurface each finger individually.

In the most severely burned patient the phalangeal bones of the index, long, ring, and little fingers were extensively exposed, extensor tendons were burned away, and in fact the little finger had

dropped off before we first saw the patient (Fig. 4-a). At surgery each phalanx was carefully chiseled and rongeured in an attempt to reach vascular bone. Only the proximal phalanges were found to bleed. The middle and distal bones were sacrificed. The proximal phalanges were resurfaced by turning back the volar skin and soft tissue flaps which remained. The fingers and flaps were sutured together side by side thereby creating a "mitten hand" and diminishing the area to be resurfaced.

At a later time the phalanges will be separated and the sides of the fingers skin-grafted. In the meantime the child uses her hand well. She is able to hold a pencil and pick up a coin with the injured hand (Fig. 4-b).

Prevention

In its "Standard for Flat Irons and Ironing Machines," published in 1954, the Underwriter's Laboratories, Inc. specify a plainly labeled manual release mechanism to permit emergency separation of the hot shoe and cloth roller. This would seem to be good protection for the adult but no protection for the youngster who cannot read. There is no specification for safety design to prevent the childhood accident which is the subject of this report. In our cases the ironer had been turned off. Nevertheless, a child less than four years of age was able to operate it.

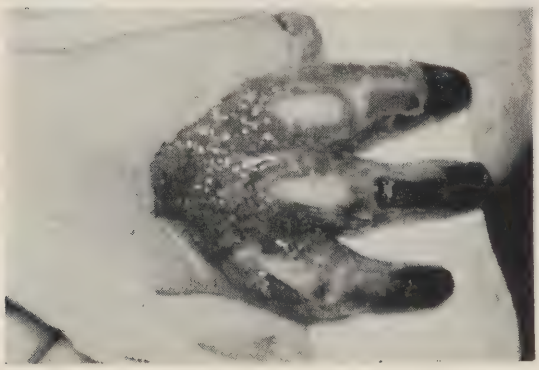


FIG. 4-a. Case 3. A. M. age 3 years. Ironer burn of left hand with destruction of distal and middle phalanges of index, long, ring, and little fingers. Photograph 25 days after accident shows absence of little finger, necrotic distal and middle phalanges, and viable proximal phalanges.

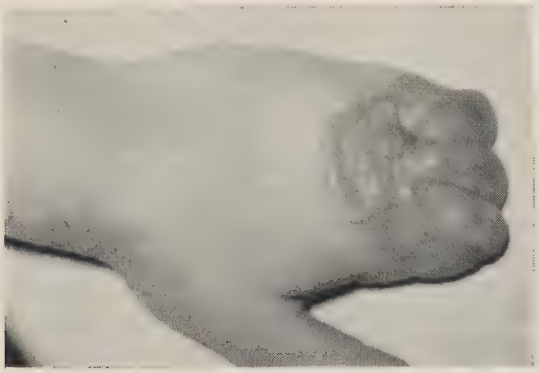


FIG. 4-b. Case 3. Appearance 4 months after initial repair. The proximal phalanges have been resurfaced with volar flaps. The knuckle area has been skin grafted. The little finger has been amputated through the metacarpal to produce a smoother contour. A "mitten hand" has been created. The fingers will be separated as a secondary procedure. In the meantime the child has good grasp function.

Total prevention of the ironer burn in children should be possible. It is primarily an obligation of the appliance manufacturers. The following additional safety features are suggested for the child's protection.

1. A foot control requiring moderate pressure and releasing automatically when the pressure is withdrawn.
2. A current inlet switch to disconnect the ironer from the house current.
3. An additional ON-OFF switch in a position inaccessible to the child.
4. A safety legend in bold print warning that both switches should be turned off except when the ironer is in actual use.
5. An automatic release of the iron shoe triggered by a predetermined amount of pressure between the shoe and the roller.

Summary

Attention is called to the characteristic deep burn of the dorsum of the child's hand produced by the household automatic ironer. Early healing and satisfactory function have been obtained with one skin-grafting operation in each of three cases. Optimum correction of deformity will require secondary elective surgery.

The ironer burn is a preventable accident. Adequate safety design is an obligation of the appliance manufacturer. Some safety features to protect the child are suggested.

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Carcinoma of the Cervix with Metastasis—A Case Report

ANTON W. OELGOETZ, M. D.

THIS 48 year old white woman was first seen at St. Ann's Hospital for Women. Her chief complaint was bleeding from the vagina. Examination disclosed a large friable, bleeding tumor arising from the upper lip of the cervix. Biopsy proved the mass to be a squamous cell carcinoma, grade 4. She was transferred to University Hospital for radiation therapy.

On February 20th she received deep x-ray to the mid-pelvis to control bleeding. She was sent back to the outpatient department to be followed and to be returned in one week for radioactive cobalt application.

On March 1st she was taken to surgery. Another biopsy specimen was taken which verified the previous diagnosis, and radioactive cobalt was inserted. On March 14th, she was again taken to surgery and radioactive cobalt inserted.

Pelvic examination at this time showed the cervix to be enlarged, quite firm, not bleeding. The uterus was enlarged and the cervical lesion showed signs of necrosis from previous radiation. There was no palpable extension of the tumor into the adnexa. She was sent back to the outpatient department to be followed and to continue external radiation.

Between March 17th and December 11th, nine Papanicolaou smears were made and studied; all of them were negative for abnormal cells.

About March 20th, she began to manifest an atypical nervous reaction; many times each day she would suddenly cry out in fear, plead for help, and then develop a mild convulsion. The convulsions were of the Jacksonian type, but did not seem to be localized to any particular part of the body. She was transferred to Receiving Hospital where she was observed and treated for five weeks. She was extremely nervous, complained of epigastric pain following meals and she became very constipated.

Because it was felt that she might be suffering from an incomplete obstruction of the colon she was sent back to University Hospital. A complete physical examination was made, including barium enemas. All tests proved negative. She was not distended, no organs or masses were palpable, the abdomen was not tender anywhere, and bowel sounds were normal. She was given castor oil with good results. The Papanicolaou test was again negative. Because the symptoms were believed to be of nervous origin she was referred back to Receiving Hospital.

From the Medical Department, Mercy Hospital, Columbus, Ohio.

The Author

● **Dr. Oelgoetz, Columbus, is a senior member of the medical staff of Mercy Hospital, and of St. Ann's Hospital for Women.**

Following a further period of observation and treatment, she was discharged to her home on December 6th. The diagnosis at this time was: Status post-Cobalt treatment for squamous cell carcinoma of the cervix; anxiety neurosis; phychophysiologic gastrointestinal reaction.

The writer was called to the home on December 10th and found the patient in bed, suffering from repeated episodes of the same fear-convulsion syndrome. The convulsions were growing more frequent and more severe. She was sent to Mercy Hospital on December 11th.

At this time she was obese, not edematous, not distended, the abdomen was not tender anywhere, but she appeared extremely ill. The cervix and vaginal vault were completely healed. No masses were palpable in the abdomen and the kidneys were not palpable. The only positive findings were a high blood urea nitrogen determination (80), and repeated catheterization disclosed a complete anuria.

She was given intravenously, slowly, continuously 3,000 cc. of 5 per cent glucose in water in an effort to overload the circulation with fluid and thus force urinary secretion by means of the water thrust of Volhard. Although 3,000 cc. of fluid were given daily for six days, she did not become edematous. The convulsions continued more frequently and more severely, until they could only be controlled with large doses of paraldehyde. On her sixth hospital day she lapsed into a deep, typically uremic coma and quietly expired.

Autopsy Report

By RUDOLPH H. VAN DER HOEVEN, M. D.

While the autopsy was thorough and complete, only relevant matters will be recorded here.

Duodenum. The duodenum is smooth and the mucosa is of normal appearance in the first portion, but in the second portion the wall is very

rigid and there are a tremendous number of nodules, suggesting a local tumor in this area.

Pancreas. The head of the pancreas is unusually firm and surrounds the duodenum in such a way by white material that I get the impression that there is a primary cancer of the head of the pancreas.

Adrenals. The left adrenal contains an adenoma about 3 cm. in diameter; the right adrenal contains a similar adenoma.

Kidneys. The kidneys are surrounded by a capsule that in both lower poles is extensively infiltrated by firm white tissue replacing most of the fatty tissue of the capsule. On sectioning the kidneys, the parenchyma shows normal cortical medulary markings and there is no reduction in the parenchyma visible. The fatty tissue surrounding the pelvis has been replaced by white cancerous tissue. The pelvis is somewhat dilated but completely embedded in this firm white tissue. The hilus of the kidneys is completely surrounded and infiltrated by the same firm white tissue that further extends to the retroperitoneal space surrounding the aorta and vena cava. It extends also along the ureters, embedding the ureters all the way into the bladder. This is part of a very extensive infiltration of retroperitoneal tissues.

Both ureters can be opened but only with much difficulty. There are several areas where the ureters are extremely compressed. On cross section the right ureter is about the thickness of a little finger, and shows practically no lumen. The mucosa however, is everywhere intact; the tumor is outside the mucosa.

Retroperitoneal Organs. The retroperitoneal organs are so unusually firm that the aorta and vena cava are firmly matted together. Opening the vena cava shows that several places the tumor from the outside perforates and grows into the wall and into the lumen. The aorta is especially narrowed in its upper portion due to compression from the outside. The tumor can be seen from the inside.

Anatomical Diagnosis

1. Extensive retroperitoneal infiltration of this cancer involving the hilus of both kidneys, surrounding tissue of ureters, vena cava, aorta and pelvic organs, including the rectum.
2. Bilateral compression of ureters.
3. Bilateral adenomas of adrenals.

Microscopic Examination

Duodenum. The duodenum is sectioned at the very place where the choledochus duct enters the duodenum. The muscular wall and the mucosa show no pathologic condition, but immediately following this there is tremendous infiltration with tumor. Part of the muscle, however, is very heavily infiltrated with tumor too.

Pancreas. The pancreas shows very heavy infiltration with tumor.

Kidney. The kidneys show mildly dilated tubules in the cortex and medulla. The glomeruli show no pathology. Fatty tissue surrounding the pelvis is tremendously infiltrated with tumor. There are areas with necrosis. The pelvis is compressed by tumor.

Ureter. The wall of the ureters show very little infiltration by tumor. Surrounding the muscle however, is a tremendous mass of tumor, partially necrotic.

Cervix. The cervical tissue is firm and is partially covered by stratified squamous epithelium. There is in numerous places carcinoma that grows in lymph vessels and also more diffusely between the tissue spaces.

Uterus. A section through the wall shows no mucosa. The wall, however, is infiltrated by tumor growing in cords in very small lymphatics.

Brain. Sections through several areas of the brain show no major pathologic condition.

Microscopic Diagnosis

1. Undifferentiated squamous carcinoma in lymphatics in cervix, uterus, ovaries and wall of bladder.
2. Massive carcinomatous infiltration in retroperitoneal tissue and fatty tissue surrounding ureters, renal pelves, duodenum, spleen and vena cava.
3. Bilateral cortical adenomas of adrenals.

Discussion

This case is remarkable in that there were absolutely no physical signs at any time indicating the massive invasion of cancer, which had frozen the entire abdomen and its contents into one solid, cement-like mass. The malignant cells invaded every tissue except the mucosa and the parenchyma of the glands, where it abruptly ceased. The duodenum, for example, was completely surrounded by the hard unyielding mass, involving all layers of the gut, down to, but not involving the mucosa. The lumen of the bowel was not encroached upon; even the mucosal pattern was normal. This is the reason why barium studies were negative.

The kidneys were embedded in the dense mass, compressed from without so that urinary secretion was prevented by external compression of the kidneys and ureters. The pelves of the kidneys were filled with the white mass, down to, but not in-

cluding the parenchyma. The surrounding fat was solidly infiltrated, indicating that the malignant cells had infiltrated by direct extension, as well as through the lymphatics. Peculiarly, the lungs, liver and brain were spared.

The cervix was healed and showed no evidence of the primary tumor site. This probably explains the failure of the Papanicolaou tests. The peritoneum was everywhere covered with fungating masses of cancer, right in the path of the x-rays.

Conclusions

1. The case is informative in that all physical signs failed even in the presence of massive malignancy, and again proves the validity of William J. Mayo's dictum: "The abdominal wall still remains the greatest hindrance to accurate diagnosis";

2. Except for control of hemorrhage, radiation was ineffective;

3. The Papanicolaou test is unreliable after irradiation.

The Significance of Fever In a Convulsing Patient

The presence or absence of fever in a convulsing patient offers another criterion for orientation. In cases of simple febrile convulsions the fever is usually high and has risen very rapidly. In fact, the appearance of the convulsion may be the first thing to bring attention to the patient's fever.

When fever has been present for some time, however, before the convulsion has occurred, some cause in addition to the fever should be sought. Acute brain diseases such as meningitis, encephalitis, brain abscess or cerebritis associated with acute otitis or mastoiditis and cerebral vascular accidents complicating acute infectious diseases are the general possibilities in this instance.

Other causes of convulsions which may or may not be associated with fever are subarachnoid or subdural hemorrhage. Subarachnoid hemorrhage is not too frequently associated with trauma, while the subdural hemorrhage, occurring more commonly in infants before the age of two years, usually follows trauma of some sort. A preretinal hemorrhage, sometimes of large proportions, is not infrequently present with hemorrhage either in the subarachnoid or subdural areas. This finding is not pathognomonic, but is strongly suggestive in patients with convulsions. When no fever is present one's attention is directed toward cerebral vascular accidents, hypertensive encephalopathy, degenerative diseases of the brain, a group of congenital disorders and brain tumor.—Larry L. Calkins, M. D., Kansas City, Kans.: *South Dakota J. Med. & Pharm.*, 10:437, November, 1957.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

The Franklin County Pelvic Cancer Delay Committee met at the Columbus Health Center on January 15, 1958, at 12 o'clock noon. Three cases were presented.

Case No. 50: The patient, a 33 year old female Negro who was seen in the Pre-Natal Clinic for routine prenatal Care, gave the history of last menstrual period November 10. She was seen the following June. Papanicolaou smear taken and was reported as Class IV. Patient was admitted to hospital. Biopsy revealed carcinoma in situ. She was re-admitted to the hospital in July. Conization revealed carcinoma in situ. Patient delivered in August. She did not return to prenatal clinic. The patient was seen again in December and found to be pregnant. Again biopsy reported as carcinoma in situ.

Comments: Patient did not return for postpartum checkup. Every patient should, and particularly those with associated disease such as a carcinoma. This patient will be followed. There was six weeks patient delay; three and one-half months institutional delay.

Case No. 51: Carcinoma of the pelvis proven grossly on routine examination at State Hospital in August. Biopsy revealed poorly differentiated carcinoma of the cervix. Patient was in clinical stage 3. From August to September she received 3,000 r. external therapy. She was admitted to University Hospital in December for cobalt therapy. Interval between therapy due to inability to have patient admitted to hospital.

Comment: Three months institutional delay.

Case No. 52: This is a 57 year old white inmate from the Columbus State Hospital with intermittent vaginal bleeding for a period of 18 to 24 months. Papanicolaou smear reported as 3 plus. Patient was given 6,800 r. central therapy with cobalt in April. This patient had no external therapy.

Comments: No immediate follow-up was made when this patient finished central therapy. This prevented adequate therapy in the sense that no external radiation could be maintained. Two months institutional delay.

Treatment of Severe Infection In the Premature Infant

Septicemia and bronchopneumonia are more hazardous in a premature than in a full-term infant because of the decreased amount of maternal antibody transferred across the placenta and because of the premature infant's inability to localize infection. Therefore, any infection has to be treated vigorously and promptly with appropriate antibiotics. Generally, the avoidance of prophylactic antibiotics is advisable unless the infant has been exposed to infection at birth. In case he contracts a severe infection later, he will be more likely to respond to antibiotics if he has received none previously.—Ruth McChesney Yohe, M. D., Des Moines: *J. Iowa M. Soc.*, 48:70, Feb., 1958.

Retinal Detachment:

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

This 20 year old white female first visited the eye clinic seven months after the onset of visual difficulty. The initial symptom was the presence of many small dark "floaters" before the right eye. Within several weeks there was gradually progressive loss of the upper visual field of this eye. This field loss subsequently extended to involve all but the inferior peripheral vision. There was no history of ocular injury or inflammation, or familial eye disease. The patient was four diopters myopic.

Examination showed a very elevated detachment of the lower two-thirds of the right retina. The macular region was detached. Several retinal tears were visible in the far periphery. The "normal" left eye exhibited advanced peripheral chorioretinal degeneration.

Retinal diathermy with scleral resection was performed. This operation was successful in reattaching the retina, however, central vision was not regained. Vision is recorded as light perception in the inferior field only.

Discussion

Almost certainly the seven months' neglect of this eye contributed to its loss. Retinal detachment should be considered as an emergency, for its rate of progression cannot be estimated. Should the macula become detached, central vision will be permanently lost despite surgery. Total detachment is inoperable. With time, a detached retina undergoes irreversible degeneration.

By means of the various techniques of retinal diathermy, scleral resection, and vitreous implantation it is reported that 60 to 80 per cent of retinal detachments can be cured. Prompt care and good patient cooperation contribute significantly toward good results.

Recognition of the existence of a detachment is greatly facilitated by the characteristic history of multiple "floaters" of rather sudden onset, followed by gradual loss of a portion of the peripheral field. Often a night's rest will permit the retina to settle, partially restoring vision, and falsely reassuring the patient. Ophthalmoscopic examination will show varying degrees of elevation of the retina, most marked in the far periphery. Proper mydriasis (as with 10 per cent Neosynephrin®) is absolutely mandatory in examination of a patient with this type of history. A far peripheral detachment (the early stage, giving best operative results) will be completely hidden behind a small pupil.

Myopia, trauma, and senile degenerations are the common causes of retinal detachments. Not all myopes, but only the 1 per cent with premature degenerative changes are susceptible. Very often both eyes become detached. Patients with this type of chorioretinal degeneration should avoid shocks such as may be sustained in football or diving, and should be alerted to report to their ophthalmologist at the first sign of floaters or field loss.

The Author

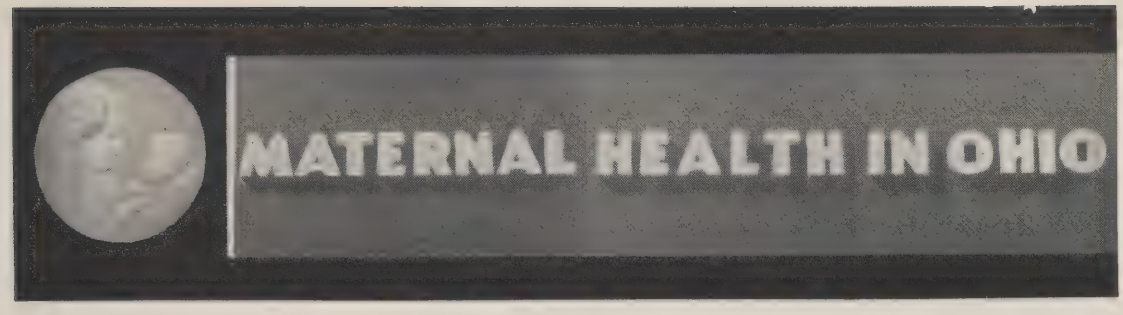
● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

Adenovirus Vaccine Is Not A Common Cold Vaccine

"It should be noted that adenovirus-caused respiratory disease is a benign and spontaneously regressive illness of relatively infrequent occurrence in adult civilians. Based on the present indication of low incidence, general use of the vaccine in adult civilian populations at this time is not justified and cannot be recommended.

"Cognizance should also be taken that adenovirus vaccine is not a common cold vaccine. In fact, in a study at Fort Dix, the vaccine was essentially without effect in reducing the incidence of mild febrile or afebrile respiratory illnesses falling into the clinical category of the common cold."

All of the foregoing underlines two most important considerations: (1) the common cold is without doubt caused by viruses, and the new methods do permit progress to be made in its study; (2) there is need for a concentrated research program at this time, as each day of delay is costing industry millions of dollars.—*Industrial Med. & Surg.*, 27:37, January, 1958.



TOPIC THIS MONTH:

Maternal Deaths* Involving Cerebral Hemorrhage

Case No. 31

This patient was a 25 year old white Para I, abortus I, who died 38 days postpartum. Her past history showed *thrombophlebitis* of the left leg in 1952 and albuminuria in 1953; the cause was undetermined. In 1954 she had a spontaneous early abortion. Her prenatal care was considered adequate; last menstrual period May 27. She delivered at term spontaneously with second degree lacerations of the perineum on March 6. The placenta was expelled spontaneously and the first postpartum day was uneventful. On the second postpartum day she developed bilateral thrombophlebitis. Anticoagulant therapy was started. On the fifth postpartum day she developed massive pulmonary infarcts and an internist was called in consultation.

In spite of a low grade fever the patient's condition improved until approximately the fourth week postpartum, when she developed severe headaches not relieved by morphine. On April 7 she became lethargic and showed a fixed dilated right pupil. She was transferred to another hospital, became comatose and developed severe generalized convulsive seizures of a decerebrate type. Her condition deteriorated rapidly. She died April 13; an autopsy was performed.

Pathological Diagnosis: Subdural hematoma, diffuse softening of the brain; lung infarcts (3 weeks old) pulmonary edema; bronchopneumonia; hemorrhage into renal pelvis and psoas muscle; retained secundines; decerebrate rigidity five days.

Comment

The Committee considered this a nonpreventable maternal death. Several missing aspects of the history provoked questions in retrospect. What was the patient's weight? Did she wear elastic hose during the antepartum period? In view of her past history, was wrapping the legs in the immediate postpartum period considered? Was she ambulated in the immediate postpartum period? Might not a quick thorough manual exploration of the uterine cavity have been done after the third stage? What experience had the internist had in similar cases? Was ligation of the inferior vena cava more than a casual consideration on the fifth postpartum day?

Only two members of the Committee ever had any experience with bilateral deep vein thrombosis, but felt that probably a vascular surgeon should have been called as a consultant on the fifth postpartum day.

Case No. 65

This patient was a 22 year old Para 0, abortus II, cesarean I, who died 29 hours postsection. Her past history showed spontaneous abortion at 11 weeks in 1947, a spontaneous abortion at 12 weeks in 1950, and an appendectomy in 1953. Her prenatal history was not known; the last menstrual period was February 10.

She was admitted to the hospital June 11 in the 17th week of gestation with the clinical diagnosis of cerebral aneurysm (circle of Willis) with subarachnoid hemorrhage, which was later confirmed by arteriograms. She was transferred to another hospital August 2, after suffering her third relapse. On August 4 (at 24 weeks gestation) the membranes ruptured spontaneously. Twelve hours later, while patient was in a comatose condition, a cesarean section was done without anesthesia and she was delivered of a 1 pound, 2 ounce, living fetus, which died shortly thereafter. Details were not reported.

The patient died 29 hours later without gaining consciousness. Autopsy permission was not granted.

Cause of Death: Acute, massive, subarachnoid hemorrhage; aneurism, circle of Willis; pregnancy uterine, 6 months, delivered by cesarean section.

Comment

By a narrow margin the Committee voted this a maternal death of a preventable nature. No member felt that this woman would have recovered completely from her cerebral accident, but members felt that performing a hysterotomy constituted a procedure of questionable benefit, which had no maternal value, although no scientific data are available to prove that normal labor exaggerates the pathology which already exists in this condition. In patients with an irreversible downhill course, where does common sense stop and worthless wasteful heroics begin?

Case No. 210

This patient was a 40 year old white Para III, abortus II, gravida IV, who died 15 hours postpartum. Her past

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

history showed four previous pregnancies: a three month abortion in 1948, an uneventful term delivery in 1949, a two and one-half months early abortion with a dilatation and curettage in 1954, and an uneventful term delivery with moderate preeclampsia in 1954. She also had a history of long term chronic bronchial asthma.

The patient registered in her fifth month, with her last period February 1. Her prenatal course was uneventful and her care was considered adequate; the highest blood pressure was recorded (early) as 144/90. She was admitted to the hospital in active labor in the 37th week of gestation on October 17, with membranes ruptured for 9 hours. After 4 hours and 15 minutes of labor she delivered spontaneously under pudendal block anesthesia without lacerations a living 5 pound, 9 ounce, baby.

Two hours postpartum (5:15 p. m. October 17) she complained of a headache. Her blood pressure was 170/90. Eight cc. magnesium sulfate was given. One hour later the blood pressure was 130/88 but headache persisted. By 11:00 p. m. she had nausea and vomiting, her speech became slurred, and patient responded poorly. Ten hours postpartum blood pressure was 134/88 and the patient was without complaints. Fourteen hours postpartum the patient vomited, but slept soundly. She was found dead at 5:50 a. m., October 18. Autopsy permission was granted.

Pathological Diagnosis: Status 15 hours postpartum; massive pontine hemorrhage with cerebral edema; hyalin thrombi of small arteries and arterioles of brain stem; chronic bronchitis, emphysema; acute membranous glomerulonephritis.

Comment

The Committee considered this a nonpreventable maternal death. Data available do not permit for a clear-cut diagnosis of toxemia in this last pregnancy. Likewise, the Committee could only surmise that postpartum administration of ergonovine may have been a supplemental contributory factor towards the accident.

Comment of Consultant

The following comment of a consultant who is a specialist in Neurological Surgery was given at the request of the Committee.

Case No. 31. It would be our considered opinion that this would represent a preventable maternal death. Whereas, certain pertinent data are not available, we would reconstruct the sequence of events as follows: Upon the second postpartum day, the patient developed bilateral thrombophlebitis and anticoagulant therapy was instituted. We are not informed regarding the prothrombin level thus achieved nor the duration of anticoagulant therapy. One month following delivery she developed symptoms incriminating the central nervous system. Severe head pain was followed by lethargy and a fixed dilated pupil developed upon the right side. This was followed by coma and generalized decerebrate type of seizures. We should point out that these serious neurological signs developed over a period of seven days, certainly ample time to forewarn the medical attendant that a lethal lesion was developing intracranially.

It would be our opinion that the subdural hematoma was caused by the anticoagulant therapy plus a mild trauma to the head. The cerebral edema was secondary to the clot. The clot plus the edema produced a hernia of the uncus and thus the decerebrate state. It is further our opinion that the surgical removal of the subdural hematoma on April 17, before irreversible brain stem changes had occurred, would have saved this patient's life.

Case No. 65. The occurrence of a spontaneous subarachnoid hemorrhage in the course of a pregnancy is a serious complication and frequently due to the rupture of an intracranial aneurysm. Carl W. Rand has recently written upon this subject in *Clinical Neurosurgery,* Vol. 3.

This patient suffered her first subarachnoid hemorrhage on June 11 and the origin of the bleeding was determined by angiography to be an intracranial aneurysm. Unfortunately the exact site of the lesion was not detailed, however. She survived for a period of two weeks, a time most favorable for surgical intervention, whether this be a ligation of the internal carotid artery in the neck or a direct intracranial attack to obliterate the aneurysm. Subsequently, she suffered two other bleeding episodes and it is our opinion that surgical intervention should have been directed toward the lesion on June 25.

Case No. 210. We agree with the Committee that this represents a nonpreventable maternal death. It is very possible that this represents an intrapontine hemorrhage secondary to an aneurysm and that the sac was destroyed by the violence of the bleeding. On the other hand, the glomerulonephritis could have induced the cerebral edema, a hernia of the uncus and thus a pontine hemorrhage.

Studies of the Distribution Of Atmospheric Molds

Molds are widely and abundantly distributed. They may be locally confined, or because of their small size, disseminated into the atmosphere and blown many miles from their origin. Atmospheric molds, like pollen, have diurnal, seasonal, and annual fluctuations.

Studies of the distribution of atmospheric molds indicate that: (1) There is a great abundance of these in the South with less seasonal variations as compared with the North, (2) *Alternaria* and *Hormodendrum* are the most commonly encountered, and (3) *Penicillium* and *aspergillus,* although widely distributed geographically, contribute little to atmospheric contamination.—H. Harold Gelfand, M. D., New York City: *New York State J. Med.,* 58:227, January 15, 1958.

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1. Welch, H.; Wright, W. W.; and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 4:620, 1957.

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The Upjohn Company, Kalamazoo, Michigan

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M.D., *President*

Presentation of Case

THIS 35 year old man was admitted to the University Hospital, Columbus, with the history of anterior right chest pain which he had had for four weeks. It was intensified by deep inspiration and radiated into the posterior thorax between the ninth and twelfth ribs. Associated with the pain, he had an occasional productive cough accompanied by a moderate amount of white sputum without blood. There were no associated chills, fever or night sweats. The pain gradually lessened but he noted instead an increasing shortness of breath and a progressive generalized weakness which persisted until admission. He also noted anoxia and lost 9 pounds in approximately six to eight weeks. Three days prior to admission he was hospitalized elsewhere and treated for his dyspnea. A chest film at that time revealed a hazy shadow between the chest wall and lung.

His past history disclosed pneumonia 14 years ago. His family history and a review of his organ systems proved noncontributory.

Physical Examination

The patient appeared fairly well nourished and apparently in acute respiratory distress with wheezing and labored breathing. His temperature was 99°F., his pulse 100; the respirations were 30 and the blood pressure 125 over 75. The skin appeared slightly cyanotic. The examination of the head and neck was not remarkable. Small nontender lymph nodes were palpable in both inguinal regions; none could be felt in the axillary, cervical, supraclavicular or epitrochlear regions. The chest revealed a slight increase in antero-posterior diameter with slight splinting on the right.

The respirations were labored with the accessory respiratory muscles participating in the breathing motions. The fremitus was increased over the right base. Both lungs showed hyperresonance with the exception of the right base, which seemed to be dull. Bilateral rhonchi accompanied the wheezing breath sounds. The heart rhythm was regular and the heart seemed not enlarged on percussion. The heart sounds were obscured but no murmurs could be heard. The abdomen was not remarkable. The extremities were not remarkable. The neurological examination yielded no abnormal findings.

Presented by

- **George P. Hummel, M.D., Columbus, and,**
- **Emmerich von Haam, M.D., Columbus.**

Edited by Dr. von Haam.

Laboratory Data

His white blood count was 16,250 with 78 per cent neutrophils; his platelets numbered 1,636,800; the hematocrit was 47 per cent; the sedimentation rate was 1.1 mm. in one hour. A bone marrow examination was reported as normal. The serological tests for syphilis were nonreactive. His blood urea nitrogen was 27 mg.; the blood sugar 122 mg. The thymol turbidity reaction was 5. The van den Bergh was .1 mg. direct and .5 mg. indirect. The total serum proteins were 8.0 Gm. with 4 Gm. albumin and 4 Gm. globulin; calcium was 10.5 mg.; the inorganic serum phosphorus was 4.8 mg., the alkaline phosphatase was 6.4 units.

Electrophoretic analysis of his blood showed a 30 per cent decrease of albumin, a 25 per cent increase of alpha-1 globulin, a 25 per cent increase of alpha-2 globulin; the beta globulins were split, and his gamma globulin was 1.6 times the normal. His urine was normal.

Roentgenographic Data

Postero-anterior and lateral films of the chest showed bilateral hilar adenopathy and partial atelectasis of the right lower and possibly the middle lobe due to bronchial obstruction. The left main-stem bronchus appeared also markedly compressed by the left hilar mass. However, the left lung seemed well aerated. Fluoroscopy of the chest showed a normal size and shape of his heart shadow and confirmed the bilateral hilar adenopathy. There was a right-sided pleural effusion with atrophy of the right diaphragm. A bronchogram seemed not advisable. Because of the pleural

effusion the roentgenologist changed his diagnosis from sarcoidosis to that of lymphoma.

Hospital Course

During his hospital stay the patient's temperature remained normal; his respirations fluctuated between 25 and 35 per minute except for several episodes of severe respiratory embarrassment with cyanosis and extremely labored breathing. These were treated with endotracheal intubation and administration of oxygen under positive pressure and helium. Finally he had to be placed in an oxygen tent. He was given a full course of nitrogen mustard in four divided doses administered intravenously.

He suddenly developed a right-sided clonic convulsion followed by cyanosis and expiratory wheezing with intercostal and suprasternal retraction. An endoctracheal tube was passed and oxygen and helium were administered under positive pressure. Gradually the dyspnea decreased and his skin color improved. A biopsy was deferred because of his critical state and the development of clonic contractions in his right upper extremity.

A check of his blood count revealed an increasing leukocytosis of 25,000 with 86 per cent polymorphonuclear leukocytes and a normal erythrocyte and platelet count. He developed two more short episodes of generalized convulsions and several clonic right-sided seizures and was treated with barbiturates. He was started on a course of x-ray therapy and 250 roentgen units were administered to his mediastinum. He expired quietly on the following day, his 13th day in the hospital.

Clinical Discussion

Dr. Hummel: We are dealing here with an obviously thin, young white male patient who came to us with an illness of only four weeks' duration and died two weeks later. His death was apparently caused by bronchial obstruction. He just did not get enough air into his lungs to maintain life. I hesitate to ask whether he was a heavy smoker, but it was not mentioned in the history. He had an episode of pleurisy on the right side and coughed up some white sputum without blood. He did not have any chills, fever or night sweats. His chest pain disappeared after about a week, which I think is the usual thing after fluid appears. He also had anorexia with some weight loss.

The pathology revealed by his physical examination was generally confined to his lungs, and the hyperresonance would suggest that he had a consolidated lesion at the right base. There were enlarged inguinal lymph nodes which were nontender. The cardiac findings were normal, and the abdominal and neurological examinations were not remarkable.

As far as the laboratory tests are concerned, we have a normal red, white and platelet count, normal urine findings and normal blood chemistries. We notice that the electrophoresis showed a decreased albumin and increased globulin fraction, but I don't believe that the electrophoretic analysis is going to help us and I will refrain from any further comment on it. A bone marrow examination was reported as normal.

The important thing during his hospital course was that his temperature remained normal, his respirations stayed rapid, and that in his few remaining days in the hospital he suffered from extreme respiratory embarrassment. Apparently a provisional diagnosis of a malignant process was made and he received a course of nitrogen mustard therapy. Later he developed a right-sided clonic convulsion and apparently almost died from respiratory failure. However, he survived that episode but remained in a critical state with generalized convulsions and several right-sided clonic seizures for which he was treated with barbiturates. He died shortly thereafter, or approximately six weeks after onset of his illness.

Lymphosarcoma?

On reading this protocol it came to my mind that this patient could very well have lymphosarcoma. When you see mediastinal lobulated shadows in the chest x-ray the first diagnosis I would entertain, at least from my own experience, would be that of lymphosarcoma. What facts speak for such a diagnosis and what factors are against it? The observation that the mediastinal enlargement was fairly symmetric would suggest that the patient had sufficient lymph node enlargement to cause bilateral bronchial obstruction. Lymphosarcoma can be present without any anemia if it is an acute sarcomatous type of reaction. On the other hand, a normal bone marrow speaks against such a diagnosis. I don't think there are any other facts which would help me to determine whether this is or is not lymphosarcoma.

Examination of the bone marrow is usually of considerable help, and a lymph node biopsy is of course of even greater help. However, a single bone marrow examination is not too reliable as it only proves that the lymphoma was not present in that particular location. The fact that he died in six weeks also speaks against such a diagnosis.

Could he have an acute Hodgkin's disease? I don't believe that Hodgkin's disease is usually quite that acute, although the course of this dis-

ease can be very rapid. It seems also that Hodgkin's disease, and particularly Hodgkin's sarcoma, usually affects older patients, and that pleural effusions are not very common in the course of this disease. The fact that more lymph nodes were affected speaks more for lymphosarcoma than for Hodgkin's disease.

Let us discuss the possibility of some type of leukemia. If he had a leukemic process with only the mediastinal nodes involved, why was he not anemic and why did not the leukemia show up in the blood smear or in the bone marrow? For this reason I am going to put leukemia far down on the list of possible diagnoses.

Could he have suffered from some infectious process and died from an overwhelming infection of some type? The short duration of his illness—six weeks—would rather agree with such a diagnosis, but neither his blood findings nor the absence of a septic type of fever are in favor of such a diagnosis, and I think that an infection has to be considered only a slight possibility. Could he have suffered from some rare condition such as a teratoma or a mesothelioma? I think these also have to be placed at the bottom of the list.

The fact that he developed convulsions and seizures while in the hospital led me to think that he had a bronchogenic carcinoma. Bronchogenic carcinoma, as far as I know, can be one of the trickiest lesions to diagnose. Two recent experiences have taught me this, where we tried all known methods including bronchoscopy with examination of the bronchial washings and removal of a lymph node from the neck, without discovering the carcinoma.

My experience with bronchogenic carcinoma is that when somebody has a chest lesion and develops a convulsion, we had best think of bronchogenic carcinoma with brain metastasis, since the brain is an extremely common place for bronchogenic carcinoma to metastasize to. Most commonly, of course, it metastasizes to the mediastinal lymph nodes and there the metastases are usually unilateral. The fact that this patient showed a bilateral enlargement of his hilar lymph nodes would seem to argue more against bronchogenic carcinoma than any other point which one could possibly mention. The lack of fever and anemia, the pleural effusion, the rapid course, the cerebral signs, and the lack of response to nitrogen mustard and possibly to x-ray therapy, if one may be permitted to judge in so short a time, are all in favor of bronchogenic carcinoma.

The diagnostic study of this individual could not be completed because he was obviously in too critical a condition for biopsies and surgical exploration. He was in terminal state and they started him on nitrogen mustard therapy obviously in the hope of getting him in somewhat better condition so that they could do a biopsy. Whether this would have been a pleural tap or a neck node biopsy, a mediastinal node biopsy or a lung biopsy would be naturally at the discretion of those in charge of the case.

The possibility that the cerebral manifestations could have been produced by nitrogen mustard needs also a few comments. He developed the first cerebral manifestations on the day following his first nitrogen mustard injection. The usual initial symptoms of nitrogen mustard intoxication are gastrointestinal: The patients develop a severe nausea and vomit. The later toxic manifestations of nitrogen mustard usually develop in one to two weeks and affect primarily the peripheral blood picture. The white count may drop in three or four days, but the red cells and the platelets, if they are affected, will show changes in one to two weeks. We have evidence that this boy's blood picture, including the platelets, was not depressed following nitrogen mustard therapy.

Metastasis

So I would like to suggest that it does not seem a very good possibility that nitrogen mustard caused some hemorrhage from one of his cerebral vessels. It is possible that he had a carcinomatous metastasis in the left internal capsule which caused his right-sided Jacksonian seizure and his generalized convulsions.

I should not neglect to mention the diagnosis of Boeck's sarcoid, which the radiologists seemed to favor. I have never seen a case of sarcoidosis of the lungs which developed pleural effusion. My understanding of sarcoid is that it not only shows hilar adenopathy but that it usually shows small granulomas throughout the lung. I have seen and treated one proven case of sarcoid with bilateral bronchial obstruction and pneumonia with fever up to 106°F. The fact that this patient apparently died from his disease, his normal temperature, and the presence of pleural effusions seem to make Boeck's sarcoid only a very remote possibility.

I don't believe any skin tests were made to rule out tuberculosis, which would have to be a primary childhood type of lymphatic tuberculosis. This form is not at all common in the white race, usually involves all lymph nodes and runs a septic course with spiking temperatures and marked debility. Perhaps we should also consider briefly a collagen disease since collagen diseases may cause enlarged lymph nodes. Their effects, however, are usually noticeable elsewhere throughout

the body, and the lymph node reaction is rather nonspecific and generalized.

So I think that we are left with bronchogenic carcinoma and lymphosarcoma as the two most likely diagnoses. I don't know any good criteria to differentiate between the two except those I have already told you: that bronchogenic carcinoma is favored by the pleural effusion, the lack of anemia, the lack of bone marrow findings, the cerebral manifestations, the lack of response to nitrogen mustard and to x-ray, and the normal temperature throughout his illness. Lymphosarcoma on the other hand is favored by the bilateral and rather symmetric mediastinal lymph node involvement. The rapid course of the disease is rather uncommon in both conditions.

As far as the immediate cause of his death is concerned, I wonder if the one dose of x-ray he received could have caused enough additional edema in and around the hilar lymph nodes to produce complete bronchial obstruction.

Clinical Diagnosis

1. Bronchogenic carcinoma of the lung.
2. Metastatic carcinoma to mediastinal lymph nodes.
3. Metastatic carcinoma to brain.

Pathological Diagnosis

1. Bronchogenic carcinoma of lung.
2. Acute hemorrhagic bronchopneumonia.
3. Metastatic carcinoma to mediastinal, mesenteric and retroperitoneal lymph nodes.
4. Metastatic carcinoma to liver, spleen, intestines and peritoneum.
5. Metastatic carcinoma to brain.

Pathological Discussion

DR. VON HAAM: I chose this case because its differential diagnosis has an important influence upon the choice of treatment. The body appeared extremely emaciated, weighing only 90 pounds. No jaundice was present and no lymph nodes could be palpated anywhere. The left pleural cavity was partially obliterated by adhesions and contained no fluid. The pericardium contained 100 cc. of fluid. The heart was small and showed no evidence of pathology. The upper lobe of the left lung appeared atelectatic, while the lower lobe of the right lung was firm, dark red and nodular.

The mediastinum was filed by a large tumor mass which was white and nodular with areas of hemorrhage and yellow necrosis. It compressed completely the right lower lobe bronchus and the left upper lobe bronchus and had eroded the wall of the right main-stem bronchus over a length of 4 cm. The trachea as well as the obstructed bronchi was filled with tenacious jelly-like mucus. The pulmonary vessels were free of emboli or thrombi and the lungs contained no other tumor masses.

The spleen was enlarged and weighed 430 grams, which fact would be in favor of lymphoma. It contained a large, firm tumor metastasis which measured 8.5 cm. in diameter. The liver was slightly decreased in size and contained two small metastatic nodules. The gallbladder and pancreas appeared normal. The gastrointestinal tract was empty and the entire mucosa from the stomach to the colon was studded with flat tumor nodules which showed characteristic umbilication and were most numerous in the upper jejunum and duodenum but also filled the lumen of the appendix. That again seemed to suggest lymphoma.

There was a polyp 1 cm. in length in the sigmoid colon which seemed thick and indurated, suggesting the possibility of a second malignant tumor. The entire mesentery and the omentum were covered with numerous tumor nodules. They also extended into the portal area but did not obstruct the large bile ducts. The adrenals were free of tumor metastasis, which is rather uncommon in bronchogenic carcinoma with such widespread metastasis. The genito-urinary tract appeared normal but some of the retroperitoneal lymph nodes contained tumor metastases.

The brain weighed 1250 grams and appeared firm and symmetrical. The left internal capsule contained a small grayish-pink tumor nodule and another slightly larger nodule was found beneath the cortex in the left superior frontal area just anterior to the Sylvian fissure. From these findings the autopsy surgeon made the diagnosis of lymphosarcoma.

Microscopic Examination

Sections through the heart showed no significant changes. Sections through the lungs showed atelectasis, edema and acute bronchopneumonia. The tumor was composed of large, very anaplastic cells with extensive necrosis and some hemorrhage. In some of the less necrotic metastatic lesions the histologic pattern could be recognized as that of a very poorly differentiated squamous cell carcinoma arising probably in the eroded portion of the right main-stem bronchus.

All metastatic lesions showed an identical picture except for the amount of necrosis, which varied greatly and which we considered an effect of the nitrogen mustard therapy. The metastatic lesions of the brain proved very hemorrhagic and were surrounded by many petechiae in the adjacent brain substance.

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"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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City Income Tax Liability . . .

This Addendum to Previous Tax Roundup for Physicians Is Given as an Example of a City Income Tax; Local Ordinances Vary, Where Effective

WHAT is the liability of physicians in regard to city income taxes in municipalities where such taxes are imposed by local ordinance? This question is asked frequently. Since it would be impractical to publish information on all Ohio cities which have such tax laws in effect (about 30), the alternative procedure is to give an example. The **example** selected is Columbus.

Columbus Ordinance

A physician in private practice in Columbus has a two-fold responsibility under the Columbus Income Tax Ordinance: (1) He must file a periodic report and pay tax on his net income, and (2) he must deduct the tax from his employees' salaries and forward it with the proper forms to the city treasurer.

Under the Columbus ordinance the following persons must file a return on Form IR-57 (Individual Return):

1. A resident of Columbus having any earned income from which full Columbus income tax liability has not been withheld;
2. A resident of Columbus conducting or engaged in a business or profession in or outside Columbus as proprietor thereof;
3. A resident of Columbus entitled to credit for travel expense not considered by the employer when withholding Columbus income tax. The filing of a return is necessary to secure refund of any tax over-withheld;
4. A non-resident of Columbus having any taxable income earned in Columbus from which full Columbus income tax liability has not been withheld;
5. A non-resident of Columbus conducting or engaged in a business or profession in Columbus as proprietor thereof;
6. A non-resident of Columbus entitled to credit for travel expenses not considered by the employer when withholding Columbus income tax on income earned in Columbus. The filing of a return is necessary to secure refund of any tax over-withheld.

A return is not required when an individual's entire taxable income for the year has been subject to withholding by the employer.

Who Must File

An individual whose income is not subject to withholding is required to file Form IR—Columbus Individual Income Tax Return, Form D1-Declaration of Estimated Columbus Income Tax, together with not less than one-fourth of the estimated tax—to be filed with the city treasurer on or before April 15, if the individual operates on a calendar year basis. The taxpayer is billed quarterly thereafter by the city auditor. Any tax liability due for 1957 and not covered by estimation should be paid at the time of filing IR-57 and the 1958 estimate. If the taxpayer has difficulty estimating his income for the year, a reliable rule is to estimate on the basis of the previous year's income. Ordinarily the estimate made for Federal Income Tax purposes may be used for the Columbus tax estimate. (Refer to December, 1957, issue of *The Journal,* page 1454).

The Columbus Division of Income Tax routinely mails forms to individuals on record as requiring them. A physician who establishes a new practice in the city should notify the division and request that his name be put on record.

Most physicians in private practice will come under the category of "resident business or professional entities owned by an individual." In such cases the income is considered to be the net profits. Allowances for the same business expense deductions as are recognized and allowed as such for Federal income tax purposes, including the methods and rates for determining depreciation, depletion and the like—with the exception of capital gains and losses. (See December 1957 issue of *The Journal,* page 1455.) Capital gains and losses are considered in arriving at net income only if such transactions are carried on regularly as business activities.

Income Not Taxed

Income not subject to the Columbus Income Tax includes dividends; interest and the like subject to the Intangible Personal Property Tax Laws of the State of Ohio; interest from obligations of the Federal or State governments or their political subdivisions; royalties from patents and copyrights; profits from the sale of capital assets; funds received from local, state or federal governments because of services in the Armed Forces of the United States by the person rendering such service, or as a result of another person rendering such service; poor relief benefits, old age and other pensions, disability benefits, annuities or

gratuities; personal earnings of persons under 18 years of age.

A wife who has taxable income in addition to that of her husband may file a joint return with him.

The Columbus income tax is 1 per cent of net income. In the case of withholdings from an employee's salary, the tax is computed on total wages before any payroll deductions are made.

Part-time workers are not excepted. The employer should deduct and make returns on his domestic or other part-time employees the same as for full-time employees.

Two or more physicians who have combined facilities for convenience—for example, share office space, services of employees, etc.—ordinarily make returns as individuals. But where there is a real partnership and the partnership files Form 1065 with the Federal government, then Form PR —Columbus Partnership Return of Income is required for the city office.

A physician who operates his office outside of the municipality and makes a limited number of calls within the city ordinarily is not taxed for fees collected on such calls. However, a physician residing outside the city but doing a substantial part of his practice in the city, would be taxed on that part of his income earned within the municipality. A physician residing in the city but doing part of his practice outside of it is taxed on his entire income.

As previously stated, this article covers only an example of a city income tax law. Other city ordinances may be different. These facts are presented only to remind physicians of the responsibilities that may exist if there is a local income tax in force. The physician who moves into a city should inquire locally as to his tax liability.

Ohio March of Dimes Grants Promote Research

Two substantial grants in Ohio were among 15 March of Dimes projects announced by the National Foundation for Infantile Paralysis. Total for the 15 projects was nearly $880,000. The two Ohio grants were the following:

University of Cincinnati, $166,538 to continue studies on a live-virus vaccine for polio, to evaluate a new diagnostic test for polio and to study a large number of newly discovered viruses. This is the project directed by Dr. Albert B. Sabin.

Western Reserve University, Cleveland, $47,463 to study the causes of aseptic meningitis.

State Medical Board Makes Its Annual Report for 1957

The State Medical Board of Ohio issued 423 graduates in medicine certificates to practice during 1957, according to the board's annual report.

In addition, 78 osteopathic applicants passed examination and were issued certificates to practice osteopathic medicine and surgery, while 74 limited practitioners were awarded certificates.

By endorsement, the board issued certificates to 318 medical applicants who had qualified in other states and six osteopathic applicants were also qualified by endorsement.

The board rejected, following examination, 88 applicants of graduates in medicine and surgery, and 33 applicants for certification by endorsement provisions. Applications of nine osteopathic physicians and surgeons were rejected following examination; seven endorsement applicants were rejected. Applications of 148 limited practitioners were rejected following examinations, as were applications of three chiropodists. The entrance examiner issued 949 preliminary education certificates to medical and osteopathic applicants, and 90 such certificates to limited practitioners.

In disciplinary activities, the board's three inspectors investigated 270 complaints of illegal practice, requiring 2,529 calls involving licensed and unlicensed practitioners. Twenty-five cases were filed in court, two dismissed and eight were awaiting trial at the end of the year. Five cases pending from previous years were concluded.

Fines amounting to $1,980 against 23 individuals were assessed, with three fines suspended. Collections amounting to $1,150 were held in abeyance pending decision of higher courts.

AMA June Session Will Be Held On the West Coast

Go west, doctor, will be the rallying cry for the medical profession, looking forward to June 23-27 and the Annual Session of the American Medical Association in San Francisco.

Complete details of the program will be announced in *The Journal of the AMA* as soon as features are complete. Registrations will be accepted on Sunday, June 22, from noon to 4:00 p. m. The Scientific and Technical Exhibits will be open to AMA physician-members only on Tuesday and Wednesday mornings.

Instructions for making hotel reservations will appear in early issues of *The Journal of the AMA.*

Between 12,000 and 15,000 physicians from all parts of the country are expected to attend, plus members of their families and others.

A number of tours will be scheduled in connection with the meeting for those who wish to combine sight-seeing with attendance at sessions.



a new era

in sulfa therapy

ONLY ONE TABLET A DAY

KYNEX*

SULFAMETHOXYPYRIDAZINE (3-SULFANILAMIDO-6-METHOXYPYRIDAZINE) LEDERLE

New authoritative studies prove that KYNEX dosage can be reduced even further than that recommended earlier.[1] Now, clinical evidence has established that a single (0.5 Gm.) tablet maintains therapeutic blood levels extending beyond 24 hours. Still more proof that KYNEX stands alone in sulfa performance—

- Lowest Oral Dose In Sulfa History—0.5 Gm. (1 tablet) daily in the usual patient for maintenance of therapeutic blood levels
- Higher Solubility—effective blood concentrations within an hour or two
- Effective Antibacterial Range—exceptional effectiveness in urinary tract infections
- Convenience—the low dose of 0.5 Gm. (1 tablet) per day offers optimum convenience and acceptance to patients

NEW DOSAGE. The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*Reg. U. S. Pat. Off.



Note These Dates

On Your 1958 Calendar and Make HOTEL RESERVATIONS Now for the 1958 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION

This list of leading downtown Cincinnati hotels is given for your convenience. Clip the coupon at the bottom of this page and mail it to the hotel of your choice with your specifications.

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NETHERLAND HILTON HOTEL, Fifth & Race Sts.	$ 7.00-11.50	$12.50-15.50	$13.00-21.00
BROADWAY HOTEL, Fourth & Broadway	$ 4.50- 7.00	$ 7.00- 9.50	$10.00-15.00
METROPOLE HOTEL, 609 WALNUT ST.	$ 5.50- 8.50	$ 8.50-12.00	$ 9.50-15.00
SHERATON-GIBSON HOTEL, 42 Walnut St.	$ 5.85-13.00	$ 9.85-16.00	$11.00-17.50
SINTON HOTEL, Fourth & Vine Sts.	$ 6.00-11.50	$ 9.00-13.50	$11.50-14.50
TERRACE HILTON HOTEL, 15 West 6th St.	$12.00-18.00		$16.00-22.00

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.
(All rates subject to change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager .....Hotel, Cincinnati, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 15, 16, 17, 1958, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April..... at..... A.M..... .....P.M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

.....

Announcing



The Official Program

for the

1958 ANNUAL MEETING

Ohio State Medical Association

CINCINNATI

Tuesday - Thursday . . . . . April, 15, 16 and 17

HERE is a gist of features and events in store for members and guests who attend the Annual Meeting. Pages 353, 354, 355, are day-by-day charts—one each for Tuesday, Wednesday and Thursday. The reader is invited to scan these charts, pinpoint the events in which he is interested, and then turn to the following pages for a chronological presentation of subjects and speakers.

Time and Place: Tuesday, Wednesday and Thursday, April 15, 16 and 17. All regular features of the OSMA program are scheduled in the Netherland Hilton Hotel. The Woman's Auxiliary will meet in the Sheraton-Gibson Hotel. Other organization programs are scheduled in places indicated in their respective notices. Some special events also are scheduled on Monday, April 14.

Registration: Headquarters will be in the Fourth Floor Foyer, Netherland Hilton Hotel. Registration opens at 8:30 a.m. each morning of the program. Admission to all sessions and to the exhibits will be by badge secured at time of registration. There is no registration charge.

Those eligible to register are members of the Ohio State Medical Association (who should present 1958 Membership Cards at time of registration); physicians from other states who are members of their respective state medical associations; residents, interns, medical students, nurses, health workers, and other guests presented at Registration Headquarters by members. The Woman's Auxiliary will provide registration for its members and others who are eligible to attend Auxiliary sessions.

Guest Speakers: Throughout the program in this issue are pictures of a number of guest speakers, physicians from other states who have attained pre-eminence in their respective fields, and who have responded to invitations to appear on the Ohio program. Refer to the chronological program for topics to be discussed by these guests.

Specialty Section Programs: These sessions are for physicians in all branches of prac-

tice, but are planned and presented by members of the respective specialties. Consult daily charts for time and place of each.

General Sessions: Here again the appeal is to physicians in all branches of practice. Some of the topics to be discussed: "Fractures," "Unfruitful Pregnancy," "The Treatment of Common Dermatological Problems," "The Doctor and His Taxes." Consult daily chart for others.

Workshop on Medical Writing: Physicians interested in writing are invited to attend this workshop on Wednesday under direction of Dr. Jonathan Forman, Editor of *The Journal* and committeeman for the American Medical Writers Association.

Scientific and Educational Exhibit: The OSMA Annual Meeting exhibit has become a highlight among exhibits throughout the country. For several years the exhibit has drawn increasing interest and attendance. The committee has selected the finest in medical investigation and clinical studies. Ample time has been provided throughout the program for frequent visits to the exhibits.

Technical Exhibit: At these exhibits, detail men from leading pharmaceutical and other supply houses will be on hand to give physicians the latest information on their respective fields. Recesses throughout the program give physicians many opportunities to visit these exhibits and chat with detail men.

House of Delegates: The policy-making body of the State Association will meet twice. The first meeting will be on Monday, April 14 following dinner. The second meeting is on Thursday morning, April 17 following breakfast. Resolutions Committees will meet between these sessions for discussions of resolutions presented at the first session.

The Woman's Auxiliary: The Woman's Auxiliary to the Ohio State Medical Association will meet concurrently with the Association. Sessions will be in the Sheraton-Gibson Hotel. All physicians' wives are invited to attend meetings and functions.

Specialty Society and Health Organization Meetings: Several organizations have scheduled programs in conjunction with the Annual Meeting. On Monday, April 14 the following organizations will conduct programs for their members: the Ohio Chapter of the American Cancer Society and the Ohio State Heart Association. Several other groups also are meeting as announced in the following pages.

The Annual Banquet is the social high spot in the Annual Meeting schedule. It's a break in an otherwise tight program of educational features. It presents an opportunity for medical colleagues from all parts of Ohio to get together in a congenial setting.

Heading the list of distinguished guests will be Dr. David B. Allman, Atlantic City, President of the American Medical Association, who has been invited to speak before the musical program and dance.

Emergency Telephone Service: The Academy of Medicine of Cincinnati will maintain an emergency telephone service for physicians attending the Annual Meeting. A booth and bulletin board will be maintained in the Fourth Floor Foyer of the Netherland Hilton Hotel. Physicians are invited to consult this bulletin board frequently since paging in the sessions or on the floor is not practical. The Cincinnati phone number at this booth will be PArkway 1-4244. It is suggested that physicians leave this number and their hotel room number at home and with their secretaries.

Alumni and Other Organization Meetings: A number of organizations have scheduled dinner meetings and other types of get-togethers for their respective members during the week of the Annual Meeting. Some of these programs are announced in the following pages. In other cases members have been notified direct.

1958 ANNUAL MEETING

Ohio State Medical Association

Netherland Hilton Hotel

Cincinnati

TUESDAY, APRIL 15

TIME	EVENT	PLACE
8:30 A. M.	**REGISTRATION OPENS**	Fourth Floor Foyer
9:00 A. M.	**OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific)
9:30 to 11:00 A. M.	**JOINT SESSION** **SECTION ON ANESTHESIOLOGY** **SECTION ON OTORHINOLARYNGOLOGY**	Parlors L-M, Fourth Floor
9:30 to 11:00 A. M.	**SECTION ON INDUSTRIAL MEDICINE**	Parlors A, B, C, D, Fourth Floor
9:30 to 11:00 A. M.	**SECTION ON OBSTETRICS AND GYNECOLOGY**	Parlors N-O, Fourth Floor
9:30 to 11:00 A. M.	**JOINT SESSION** **SECTION ON PEDIATRICS** **SECTION ON RADIOLOGY** (In cooperation with Ohio Chapter, American Academy of Pediatrics)	Pavillon, Fourth Floor
9:30 to 11:00 A. M.	**SECTION ON UROLOGY**	Parlors E-F, Fourth Floor
11:00 to 11:30 A. M.	**RECESS FOR TOUR OF EXHIBITS**	
11:30 A. M. to 12:30 P. M.	**CONTINUATION OF MORNING SESSIONS**	
2:00 to 3:00 P. M.	**GENERAL SESSION** "The Doctor and His Taxes"	Pavillon, Fourth Floor
3:00 to 3:30 P. M.	**RECESS FOR TOUR OF EXHIBITS**	
3:30 to 5:00 P. M.	**GENERAL SESSION** "Fractures"	Pavillon, Fourth Floor

1958 ANNUAL MEETING

Ohio State Medical Association

Netherland Hilton Hotel

Cincinnati

WEDNESDAY, APRIL 16

TIME	EVENT	PLACE
8:30 A. M.	**REGISTRATION**	Fourth Floor Foyer
9:00 to 9:30 A. M.	**TOUR OF EXHIBITS**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific)
9:30 to 11:00 A. M.	**COMBINED SESSION** **SECTION ON GENERAL PRACTICE** **SECTION ON INTERNAL MEDICINE** **SECTION ON RADIOLOGY** **SECTION ON SURGERY**	Pavillon, Fourth Floor
9:30 to 11:00 A. M.	**JOINT SESSION** **SECTION ON NERVOUS AND MENTAL DISEASES** **SECTION ON PHYSICAL MEDICINE** (In cooperation with Ohio Psychiatric Association)	Parlors A, B, C, D, Fourth Floor
9:30 to 11:00 A. M.	**SECTION ON NEUROLOGICAL SURGERY**	Parlors L-M, Fourth Floor
9:30 to 11:00 A. M.	**SECTION ON OPHTHALMOLOGY**	Parlors N-O, Fourth Floor Netherland Hilton Hotel
10:00 A. M. to 12:00 Noon	**WORKSHOP ON MEDICAL WRITING**	Parlors E-F, Fourth Floor
11:00 to 11:30 A. M.	**RECESS FOR TOUR OF EXHIBITS**	
11:30 A. M. to 12:30 P. M.	**CONTINUATION OF MORNING SESSIONS**	
2:00 to 5:00 P. M.	**OHIO PSYCHIATRIC ASSOCIATION**	Parlors A, B, C, D, Fourth Floor
2:00 to 3:00 P. M.	**GENERAL SESSION** "It's Your A. M. A." "The Treatment of Hypertension"	Pavillon, Fourth Floor
3:00 to 3:30 P. M.	**RECESS FOR TOUR OF EXHIBITS**	
3:30 to 5:00 P. M.	**GENERAL SESSION** "Unfruitful Pregnancy" "Ophthalmoscopic Findings in Relation to General Medicine" "The Doctor Defendant"	Pavillon, Fourth Floor
7:30 P. M.	**ANNUAL BANQUET**	Pavillon, Fourth Floor

1958 ANNUAL MEETING

Ohio State Medical Association

Netherland Hilton Hotel

Cincinnati

THURSDAY, APRIL 17

TIME	EVENT	PLACE
8:00 A. M.	**COMPLIMENTARY BREAKFAST FOR MEMBERS OF THE HOUSE OF DELEGATES, TO BE FOLLOWED BY FINAL BUSINESS SESSION**	Parlors L, M, N, O, Fourth Floor
8:30 A. M.	**REGISTRATION**	Fourth Floor Foyer
9:00 to 10:00 A. M.	**TOUR OF EXHIBITS**	Hall of Mirrors, Third Floor (Technical) North Hall, Fourth Floor (Technical) South Hall, Fourth Floor (Scientific)
10:00 to 11:00 A. M.	**GENERAL SESSION** "The Treatment of Common Dermatological Problems"	Pavillon, Fourth Floor
11:00 to 11:30 A. M.	**RECESS FOR TOUR OF EXHIBITS**	
11:30 A. M. to 12:30 P. M.	**GENERAL SESSION** "What's New?"	Pavillon, Fourth Floor
2:00 to 3:30 P. M.	**GENERAL SESSION** "The Acute Abdomen"	Pavillon, Fourth Floor
3:30 P. M.	**ADJOURNMENT**	

DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
FIRST DISTRICT		
ADAMS	Richard L. Woodyard	Kenneth C. Jee
BROWN	John R. Donohoo	Charles H. Maly
BUTLER	Neil Millikin	Paul N. Ivins
	John A. Carter	John L. Bauer
CLERMONT	Carl A. Minning	Alfred G. Schulze
CLINTON	Edmond K. Yantes	Richard R. Buchanan
HAMILTON	Richard B. Homan	Charles D. Bahl
	Harry K. Hines	Henry C. Beekley
	Charles W. Hoyt	F. Paul Duffy
	Daniel V. Jones	Virginia M. Esselborn
	J. Harold Kotte	Robert E. Howard
	Robert D. Mansfield	Howard F. Pfister
	James D. Phinney	Robert M. Sherman
	Virgil A. Plessinger	Clayton R. Sikes, Jr.
	Thomas J. Radley	William C. Thornell
	Stuart A. Schloss	Robert W. Woliung
	Carl F. Vitler	
HIGHLAND	J. Martin Byers	Glendon E. Parry
WARREN	O. L. Layman	H. G. Berninger
SECOND DISTRICT		
CHAMPAIGN	Isador Miller	V. R. Frederick
CLARK	Ray M. Turner	J. Harold Shanklin
	John M. Summers	Elliott W. Schilke
DARKE	Maurice M. Kane	Ross M. Zeller
GREENE	Paul D. Espey	C. G. McPherson
MIAMI	Dale A. Hudson	E. T. Pearson
MONTGOMERY	Kenneth D. Arn	John R. Brown
	Lynne E. Baker	Robert M. Craig
	H. R. Cammerer	William H. Fries
	T. L. Light	Charles L. Kagay
	R. E. Pumphrey	S. L. Weinberg
PREBLE	C. J. Brian	E. P. Trittschuh
SHELBY	George J. Schroer	Thomas W. Hunter
THIRD DISTRICT		
ALLEN	Donald W. English	Walter C. Beery
	Fred P. Berlin	Margaret E. Belt
AUGLAIZE	Elizabeth Y. Kuffner	
CRAWFORD	Carl J. Ide	B. M. Mansfield
HANCOCK	Harold K. Treece	Frank M. Wiseley
HARDIN	Floyd M. Elliott	Louis A. Black
LOGAN	H. L. Mikesell	Douglas W. Beach
MARION	Thomas N. Quilter	John T. Boxwell
MERCER		
SENECA	Walter A. Daniel	Edmund F. Ley
VAN WERT	Edwin Wm. Burnes	A. C. Diller
WYANDOT	Allen F. Murphy	F. M. Smith
FOURTH DISTRICT		
DEFIANCE	F. M. Lenhart	William S. Busteed
FULTON	Robert T. Blair	Benjamin Reed
HENRY	Thomas F. Tabler	E. C. Winzeler
LUCAS	J. Lester Kobacker	Henry D. Cook
	A. J. Kuehn	E. F. Glow
	E. F. Ockuly	Charles R. Marlowe
	Frank F. A. Rawling	D. C. Nouse
	Howard E. Smith	Maurice A. Schnitker
	G. H. Start	R. P. Whitehead
OTTAWA	George A. Boon	Cyrus R. Wood
PAULDING	D. E. Farling	K. A. Pritchard
PUTNAM	James B. Overmeier	
SANDUSKY	A. C. Rini	E. W. Sanders
WILLIAMS	John R. Riesen	Paul G. Meckstroth
WOOD	Roger A. Peatee	S. A. Kosewick
FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	James G. Macaulay
CUYAHOGA	James O. Barr	C. R. Jablonoski
	Joseph L. Bilton	Albert L. Jones
	G. H. Brown	Thomas D. Kinney
	Francis L. Browning	A. Macon Leigh
	John H. Budd	Frank J. Rack
	C. A. Colombi	J. M. Rossen
	Eduard Eichner	D. K. Spitler
	Eugene A. Ferreri	A. C. Corcoran
	John J. Grady	James A. Gavin
	Harry A. Haller	Edward W. Shannan
	J. B. Hazard	
	H. D. Iler	
	Fred R. Kelly	
	John A. Kenney, Jr.	
	M. H. Lambright, Jr.	
	Paul A. Mielcarek	
	Philip J. Robechek	
	Paul J. Schildt	
	Edwin L. Smith	
	Leo H. Simoson	
GEAUGA	Walter C. Corey	William A. Reed
LAKE	Benjamin S. Park	James G. Powell

Counties	Delegates	Alternates
SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	P. H. Beaver
MAHONING	Asher Randell	Craig C. Wales
	Paul J. Mahar	Charles W. Stertzbach
	Harlan P. McGregor	John J. McDonough
PORTAGE	Myron W. Thomas	
STARK	J. B. Walker	D. E. Leavenworth
	Wm. A. White, Jr.	Lloyd L. Dowell
	John R. Seesholtz	A. E. Boyles
	R. L. Rutledge	Mark Herbst
SUMMIT	H. O. Musser	R. H. Breneman
	Carl C. Nohe	Thomas S. Brownell
	Harold E. Muller	Donald M. Traul
	Philip B. deMaine	Harvey A. Karam
	Joseph J. Eckert	Edward A. Sawan
TRUMBULL	Raymond Ralston	S. J. Shapiro
	Elmer G. Caskey	Joseph M. Gledhill
SEVENTH DISTRICT		
BELMONT	B. C. Diefenbach	David Danenberg
CARROLL	Glenn C. Dowell	Samuel L. Weir
COSHOCTON	W. R. Agricola	Norman L. Wright
HARRISON	George E. Henderson	Gerald E. Vorhies
JEFFERSON	Earl Rosenblum	Stanley L. Burkhardt
MONROE		
TUSCARAWAS	Joseph W. Hamilton	R. E. Rinderknecht
EIGHTH DISTRICT		
ATHENS	Eleanora Schmidt	Tamin Najm
FAIRFIELD	J. L. Kraker	Chester P. Swett
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	R. G. Plummer	Carl L. Petersilge
MORGAN	Henry Bachman	E. Galen Rex
MUSKINGUM	A. C. Ormond	J. Herbert Bain
NOBLE	E. G. Ditch	Norman S. Reed
PERRY	Charles E. Bope	Michael P. Clouse
WASHINGTON	Kenneth E. Bennett	Ford E. Eddy
NINTH DISTRICT		
GALLIA	Keith R. Brandeberry	Homer B. Thomas
HOCKING	C. T. Grattidge	H. M. Boocks
JACKSON	C. C. Fitzpatrick	A. R. Hambrick
LAWRENCE	George N. Spears	Thomas E. Miller
MEIGS	R. P. Daniels	E. F. Maag
PIKE	Chas. L. Critchfield	Mack E. Moore
SCIOTO	Wm. M. Singleton	Richard L. Wagner
VINTON	H. D. Chamberlain	
TENTH DISTRICT		
DELAWARE	Robert S. Caulkins, Jr.	Douglas L. Smith
FAYETTE	James E. Rose	Frank C. King
FRANKLIN	Perry R. Ayres	Drew J. Arnold
	Mel A. Davis	William F. Bradley
	Philip B. Hardymon	Wiley L. Forman
	Edward W. Harris	James C. Good
	Reuben B. Hoover	John R. Huston
	Robert M. Inglis	Charles R. McClave
	Charles W. Pavey	Clark P. Pritchett
	Judson D. Wilson	William P. Smith, Jr.
KNOX	Henry T. Lapp	Raymond S. Lord
MADISON	Sol Maggied	Paul G. H. Wolber
MORROW	Joseph P. Ingmire	F. W. Kubbs
PICKAWAY	Frank R. Moore	E. L. Montgomery
ROSS	Robert E. Swank	Ralph W. Holmes
UNION	Fred C. Callaway	E. J. Marsh
ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	
ERIE	E. J. Meckstroth	
HOLMES	N. P. Stauffer	A. J. Earney
HURON	Owen J. Nicholson	John V. Emery
LORAIN	George R. Wiseman	John W. Newman
	James T. Stephens	Henry E. Kleinhenz
MEDINA	Nevin J. M. Klotz	Richard W. Avery
RICHLAND	P. O. Staker	H. G. Knierim
	Harry Wain	R. H. Barnes
WAYNE	Albert B. Huff	Adrian J. Hartzler

OFFICERS

Pres. Robert S. Martin
Pres.-Elect George A. Woodhouse
Treas. Geo. J. Hamwi
Past-Pres. Charles L. Hudson

COUNCILORS

First Frank H. Mayfield
Second R. Dean Dooley
Third James R. Jarvis
Fourth Paul F. Orr
Fifth George W. Petznick
Sixth Carl A. Gustafson
Seventh Robert E. Hopkins
Eighth Wm. D. Monger
Ninth C. L. Pitcher
Tenth E. H. Artman
Eleventh H. T. Pease

MONDAY, APRIL 14

6:00 P. M.

HOUSE OF DELEGATES

COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, OFFICERS AND COUNCILORS, TO BE FOLLOWED BY BUSINESS SESSION

Restaurant Continental, Lobby Floor

Call to order by George X. Schwemlein, M. D., Cincinnati, President of the Cincinnati Academy of Medicine.

Introduction of the President, Robert S. Martin, M. D., Zanesville.

Consideration of the minutes of the last Annual Meeting (June, 1957, issue of *The Journal*).

Introduction of honored guests.

Introduction of President of Woman's Auxiliary.

Appointment of Reference Committees by the President:

Credentials.
President's Address.
Resolutions.
Tellers and Judges of Election.

Report of Committee on Credentials of Delegates.

Nomination and Election of Committee on Nominations: (Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the Second Session, Thursday, 8:00 A. M., its recommendations in the form of a ticket containing nominees for offices, to be filled at this meeting as required under the Constitution and By-Laws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committee on Resolutions, and reported back to the House of Delegates at the Thursday morning session before any action can be taken. All resolutions must be typewritten and submitted in triplicate.)

Announcements of meeting places of Committee on Nominations and Reference Committees by chairmen of the committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

Other Monday Programs

Programs on Monday, April 14, include those of the Ohio State Heart Association and the Ohio Cancer Conference. Details on these meetings will be found on pages 371-372 in this issue.

TUESDAY, APRIL 15

8:30 A. M.

REGISTRATION OPENS

Fourth Floor Foyer

9:00 A. M.

OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS

TUESDAY, APRIL 15

9:30 A. M.

JOINT SESSION
SECTION ON ANESTHESIOLOGY
SECTION ON OTORHINOLARYNGOLOGY

Parlors L-M, Fourth Floor

This program for the joint session of the two sections was arranged by the following officers of the sections: John P. Garvin, M. D., Columbus, Chairman, Donald E. Hale, M. D., Cleveland, Secretary, Section on Anesthesiology; William C. Thornell, M. D., Cincinnati, Chairman, and Sylvester C. Missal, M. D., Cleveland, Secretary, Section on Otorhinolaryngology.

THE PARTICIPANTS

Irving I. Cramer, M. D., Cleveland, Senior Clinical Instructor, Western Reserve University School of Medicine.

Nicholas G. DePiero, M. D., Cleveland, Director, Department of Anesthesiology, Marymount Hospital, Garfield Heights.

Floyd J. Fowler, M. D., Akron, Otolaryngologist, Senior Staff, Akron General, City and St. Thomas Hospitals.

Sidney W. Helperin, M. D., Cleveland, Senior Visiting Anesthesiologist, Mount Sinai Hospital of Cleveland.

George F. Parker, M. D., Springfield, Director, Department of Anesthesiology, Mercy Hospital.

Clare R. Rittershofer, M. D., Cincinnati, Associate Clinical Professor of Pediatrics, University of Cincinnati College of Medicine.

Richard H. Stahl, M. D., Cuyahoga Falls, Fellow, American College of Surgeons.

Glenn E. Willoughby, M. D., Marion, Anesthesiologist, Marion General Hospital.

Presiding: Dr. Garvin.

9:30 **Modern Approach to the Problems of Tonsil and Adenoid Surgery** (Panel Discussion)

Moderator: Dr. Stahl.

Members of Panel: Drs. DePiero, Fowler, Rittershofer and Willoughby.

11:00 Recess for Tour of Exhibits.

11:30 **The Effects of Air Conditioning Upon the Respiratory Tract**—Dr. Cramer.

11:50 **Anesthesia for Oral Endoscopy**—Dr. Helperin.

12:05 **Complications of Endotracheal Intubation**—Dr. Parker.

12:20 Election of Officers for 1959.

TUESDAY, APRIL 15

9:30 A. M.

SECTION ON INDUSTRIAL MEDICINE

Parlors A, B, C, D, Fourth Floor

Chairman.....Rex H. Wilson, M. D., Akron
Secretary.....Robert M. Andre, M. D., Portsmouth

THE PARTICIPANTS

Keith C. Keeler, M. D., Akron, Medical Director, Rehabilitation Center of Summit County, Inc.

Robert A. Kehoe, M. D., Cincinnati, Professor of Industrial Medicine, University of Cincinnati College of Medicine.

Joseph A. Quigley, M. D., Cincinnati, Director of Health and Safety, National Lead Company of Ohio.

9:30 Remarks by the Chairman.

9:40 **Rx—"Light Duty"—What Does It Mean?**—Dr. Keeler.

10:15 **Medical Research and Medical Practice in Industry—The Doctor's Dilemma**—Dr. Kehoe.

11:00 Recess for Tour of Exhibits.

11:30 Election of Officers for 1959.

11:45 **The Handling of Radioactive Materials—Knowledge or Death**—Dr. Quigley.

TUESDAY, APRIL 15

9:30 A. M.

SECTION ON OBSTETRICS AND GYNECOLOGY

Parlors N-O, Fourth Floor

Chairman.....H. Thomas Atkins, M. D., Hamilton
Secretary.....Harry E. Ezell, Jr., M. D., Columbus

THE PARTICIPANTS

Keith R. Brandeberry, M. D., Gallipolis, Head of Department of Obstetrics and Gynecology, Holzer Hospital.

Albert Hirsheimer, M. D., Dayton, Diplomate, American Board of Obstetrics and Gynecology.

Zeph J. R. Hollenbeck, M. D., Columbus, Professor of Obstetrics and Gynecology, Ohio State University College of Medicine.

Arthur G. King, M. D., Cincinnati, Instructor of Obstetrics, University of Cincinnati College of Medicine.

L. Burdett Wylie, M. D., Lakewood, Assistant Clinical Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine.

9:30 **Prevention and Treatment of Abortions** (Panel Discussion)
Moderator: Dr. King.
Members of Panel: Drs. Brandeberry, Hirsheimer and Wylie.

10:45 Election of Officers for 1959.

11:00 Recess for Tour of Exhibits.

11:30 **An Evaluation of the Franklin County Cancer Survey Project**—Dr. Hollenbeck.

12:30 Luncheon, Parlor G.
Open to all members, their wives and guests of the Section on Obstetrics and Gynecology. Make reservations by mail with H. Thomas Atkins, M. D., 401 Park Avenue, Hamilton.

Emergency Telephone Service Will Be Maintained by Cincinnati Academy

The Cincinnati Academy of Medicine has arranged special telephone facilities for physicians atending the meeting. A booth will be set up near the Registration Headquarters, Fourth Floor Foyer, and a bulletin board will be maintained on which names of physicians being called will be placed. The special telephone number at the booth will be PArkway 1-4244.

Physicians may wish to leave this number with their secretaries. The physician also should leave information at his home and office as to which hotel he will be in for possible contact at other times. Since it has been found impractical to page physicians in assembly halls or on the exhibit floor, members should consult bulletin board frequently for pending calls.

Members and Guests Invited To Visit Cincinnati Art Museum

The Cincinnati Art Museum, one of the outstanding museums in the United States, has extended an invitation to all convention delegates to visit its collections. An almost complete review of the World's great civilizations is offered through comprehensive collections of sculpture, paintings, prints, Near and Far Eastern art and decorative arts. The Museum is open daily from 10 a. m. to 5 p. m.; Sunday and holiday hours are 2 to 5 p. m. Located in Eden Park, it is a 15 minute trip from downtown area via "Zoo Eden" Bus No. 49, or a 10 minute drive via Gilbert Avenue to Eden Park Entrance. Admission is free.

The Scientific and Educational Exhibits

A list of Scientific and Educational Exhibits is published in this issue, pages 368-370. Members are invited to study the list and make a point to visit exhibits of particular interest during the Annual Meeting. Ample time is provided throughout the program for frequent visits.

TUESDAY, APRIL 15

9:30 A. M.

JOINT SESSION
SECTION ON PEDIATRICS
SECTION ON RADIOLOGY

Pavillon, Fourth Floor

This program for the joint session of the two sections was arranged in cooperation with the Ohio Chapter, American Academy of Pediatrics and by the following officers of the sections: Minor W. Seymour, M. D., Columbus, Chairman, Arthur Spreen, M. D., Cincinnati, Secretary, Section on Pediatrics; Carroll C. Dundon, M. D., Cleveland, Chairman, Clarence J. Morrell, M. D., Cleveland, Secretary, Section on Radiology.

THE PARTICIPANTS

Edith L. Potter, M. D., Chicago, Ill., Professor of Pathology, Department of Obstetrics and Gynecology, The University of Chicago, the School of Medicine.

Guido Currarino, M. D., Cincinnati, Assistant Professor of Radiology and Pediatrics, University of Cincinnati College of Medicine.

Carl A. Koch, M. D., Cincinnati, Assistant Clinical Professor of Pediatrics, University of Cincinnati College of Medicine.

Benjamin H. Landing, M. D., Cincinnati, Assistant Professor of Pathology & Pediatrics, University of Cincinnati College of Medicine.

Thomas Oliver, Jr., M. D., Columbus, Assistant Professor of Pediatrics, Ohio State University College of Medicine.

James M. Sutherland, M. D., Cincinnati, Assistant Professor of Pediatrics, University of Cincinnati College of Medicine.

Presiding: Dr. Seymour and Dr. Dundon.

9:30 **Respiratory Distress of the Newborn** (Panel Discussion)
Moderator: Dr. Landing.
Members of Panel: Drs. Currarino, Koch, Oliver, Potter and Sutherland.

10:30 Recess for Tour of Exhibits.

11:00 Continuation of Panel Discussion.

11:30 Question and Answer Period.

12:15 Election of Officers for 1959, Section on Pediatrics and Section on Radiology.

12:25 - 12:55 Business Meeting, Ohio Chapter, American Academy of Pediatrics.

* * *

Ohio Chapter, Am. Academy of Pediatrics To Hold Session and Banquet

On Tuesday afternoon the Ohio Chapter, American Academy of Pediatrics will hold a clinical session from 3 to 5 o'clock at Children's Hospital, Elland and Bethesda Avenues. In the evening the chapter will sponsor a banquet at the University Club, 401 East Fourth St., starting at 7 o'clock.

Guest Participants



Wm. W. Scott, M. D.
Baltimore



Edith Potter, M. D.
Chicago

TUESDAY, APRIL 15

9:30 A. M.

SECTION ON UROLOGY

Parlors E-F, Fourth Floor

Chairman.....Richard S. Graves, M. D., Dayton
Secretary.....John P. Smith, M. D., Columbus

THE PARTICIPANTS

George Austen, Jr., M. D., Cleveland, Associate Clinical Professor of Urology, Western Reserve University School of Medicine.

Bernard J. Begley, M. D., Springfield, Member, North Central Section, American Urological Society.

William W. Scott, M. D., Ph. D., Baltimore, Md., Professor of Urology, Johns Hopkins University School of Medicine.

T. Brent Wayman, M. D., Cincinnati, Director, Department of Urology, University of Cincinnati College of Medicine.

THE MANAGEMENT OF CARCINOMA OF THE PROSTATE

9:30 **The Diagnosis of Carcinoma of the Prostate**—Dr. Wayman.

9:50 **The Present Status of Radioactive Isotopes in Treating Carcinoma of the Prostate**—Dr. Begley.

10:10 **The Surgical Management of Carcinoma of the Prostate**—Dr. Austen.

10:30 **Hormones and Prostatic Cancer**—Dr. Scott.

11:00 Recess for Tour of Exhibits.

11:30 Panel Discussion, Questions and Answers.

12:15 Election of Officers for 1959.

An Invitation

All members of the Ohio State Medical Association may attend business sessions of the House of Delegates; also meetings of reference committees.

TUESDAY, APRIL 15

2:00 P. M.

GENERAL SESSION

Pavillon, Fourth Floor

THE PARTICIPANTS

E. C. Baker, M. D., Youngstown, Director of Radiology, Youngstown Hospital Association.

N. J. Giannestras, M. D., Cincinnati, Clinician, Orthopedic Department of Surgery, University of Cincinnati College of Medicine.

Paul A. Jones, M. D., Zanesville, Radiologist, Good Samaritan and Bethesda Hospitals, Zanesville.

J. I. Kendrick, M. D., Cleveland, Orthopedic Surgeon, Cleveland Clinic.

Joseph F. McElligott, New York, N. Y., Business and Tax Consultant to Members of the Medical Profession.

Guest Participant



Jos. F. McElligott
New York

Arnold D. Piatt, M. D., Newark, Director, Departments of Radiology, Newark Hospital, Mercy and Memorial Hospitals, Mt. Vernon, and Coshocton Memorial Hospital.

Presiding: Maurice M. Kane, M. D., Greenville, Member, Committee on Scientific Work.

2:00 **The Doctor and His Taxes**—Mr. McElligott.

3:00 Recess for Tour of Exhibits.

3:30 **Fractures**

Moderator: Dr. Baker.

Tomography of the Sternoclavicular Area—Dr. Baker.

The Radiologist's Role in the Pinning of Fractures of the Hip—Dr. Jones.

Some Significant Aspects in Fractures of the Calcaneus—Dr. Piatt.

Fractures of the Ankle—Dr. Giannestras.

General Principles of the After-Care of Fractures—Dr. Kendrick.

Ohio physicians have been invited to submit applications for scientific exhibits for the Wisconsin Academy of General Practice annual assembly, September 15-16 in the Milwaukee Auditorium. Details may be obtained from Robert A. Dufour, Executive Secretary, 758 N. 27th Street, Milwaukee 8, Wis.

Give Hotels a Break—If You Can't Attend, Cancel Your Reservation Promptly

The most dreaded and the most costly letters in the alphabet of problems of the hotel industry are D. N. S., according to hotel officials.

These mean "Did Not Show." Further they mean that the hotel has accepted and confirmed a reservation for a room, held it in good faith against opportunity to sell it, often pressure to sell it, and now finds it empty. The most absolute and irretrievable economic loss in all business is the hotel room that was empty last night. When that room could have been sold, and was in demand, the loss is doubly critical.

Why are we pointing these things out to OSMA members? Because when the Ohio State Medical Association meets in Cincinnati April 15-17 past history shows that the hotels will encounter the "D.N.S." headache to some extent.

Help to treat that headache and eliminate it. If you hold a reservation and circumstances arise that make your trip impossible, *cancel* by wire, or if the time allows, by letter to the manager of the hotel where you hold reservations.

Some other doctor will want that room. The hotel wants to sell it. Cooperate with both. Help the hotels to cooperate with you and other OSMA members.

Resolutions To Be Presented at 1958 Meeting Should Be Sent for Publication in Journal

County Medical Societies which plan to have their delegates introduce resolutions at the 1958 Annual Meeting of the Ohio State Medical Association, April 15-17, Cincinnati, or individual delegates who have prepared resolutions for consideration at the Cincinnati meeting, should, if possible, submit copies of such resolutions to the Columbus Office so they can be published in the April issue of *The Journal* and mimeographed for distribution to all delegates in advance of the meeting.

Copies of such resolutions should be sent to the Columbus office at once.

This will give delegates an opportunity to know in advance the subjects to be considered and a chance to discuss such matters with their local societies to receive instructions on matters of policy involved.

WEDNESDAY, APRIL 16

8:30 A. M.

REGISTRATION

Fourth Floor Foyer

9:00 to 9:30

TOUR OF EXHIBITS

WEDNESDAY, APRIL 16

9:30 A. M.

COMBINED SESSION
SECTION ON GENERAL PRACTICE
SECTION ON INTERNAL MEDICINE
SECTION ON RADIOLOGY
SECTION ON SURGERY

Pavillon, Fourth Floor

This program for the combined session of the four sections was arranged by the following officers of the sections; Raymond M. Kahn, M. D., Dayton, Chairman, Wm. L. Hall, M. D., Columbus, Secretary, Section on General Practice; John D. Battle, Jr., M. D., Cleveland, Chairman, John A. Prior, M. D., Columbus, Secretary, Section on Internal Medicine; Carroll C. Dundon, M. D., Cleveland, Chairman, Clarence J. Morrell, M. D., Cleveland, Secretary, Section on Radiology; Edwin H. Ellison, M. D., Columbus, Chairman, Richard W. Zollinger, M. D., Columbus, Secretary, Section on Surgery.

THE PARTICIPANTS

Floyd M. Beman, M. D., Columbus, Associate Professor, Department of Medicine (Gastroenterology), Ohio State University College of Medicine.

Horace B. Davidson, M. D., Columbus, Clinical Professor of Pathology, Ohio State University College of Medicine.

Benjamin Felson, M. D., Cincinnati, Professor and Director, Department of Radiology, University of Cincinnati College of Medicine.

Stanley R. Friesen, M. D., Kansas City, Kans., Associate Professor of Surgery and Oncology, University of Kansas School of Medicine.

Emmerich von Haam, M. D., Columbus, Professor and Chairman, Department of Pathology, Ohio State University College of Medicine.

Stanley O. Hoerr, M. D., Cleveland, Professor of Surgery, Frank E. Bunts Educational Institute.

Hans Popper, M. D., New York, N. Y., Professor of Pathology, Columbia University College of Physicians and Surgeons.

Herbert W. Salter, M. D., Cleveland, Director of General Practice Department, Doctors Hospital, Cleveland Heights.

Leon Schiff, M. D., Cincinnati, Professor of Clinical Medicine, University of Cincinnati College of Medicine.

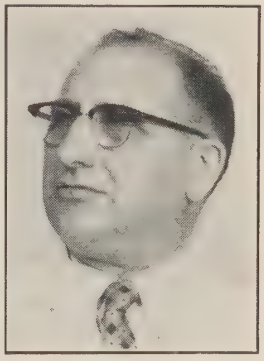
Roger D. Williams, M. D., Columbus, Assistant Professor, Department of Surgery, Ohio State University College of Medicine.

Edmond K. Yantes, M. D., Wilmington, Chairman, Committee on Rural Health, Ohio State Medical Association.

Guest Participants



Stanley R. Friesen, M. D.
Kansas City



Hans Popper, M. D.
New York

Presiding: Dr. Battle.

9:30 **Diagnosis and Management of Diseases of the Liver and Extrahepatic Biliary System** (Panel Discussion)
Moderator: Dr. Hoerr.
Members of Panel: Drs. Felson, von Haam, Popper, Schiff, Williams, and Yantes.

10:30 **Correlation of Liver Function Studies with Hepatic Pathology**—Dr. Popper.

11:00 Recess for Tour of Exhibits.

11:30 **Surgical Aspects of Jaundice**—Dr. Friesen.

12:00 **Clinicopathological Conference**
A Patient with Jaundice
Moderator: Dr. Davidson, representing the Ohio Society of Pathologists.
Participants: Drs. Beman, Felson, Friesen and Salter.

12:30 Election of Officers for 1959.

Women Physicians Will Hold Luncheon Meeting in Cincinnati

On Wednesday, April 16, Branch 11 of the American Medical Women's Association is planning a luncheon for all the women physicians attending the Ohio State Medical Association meetings in Cincinnati. It will be held at the Netherland Hilton Hotel at 12:30. Advance reservations ($3.00) may be mailed to Dr. Margaret Schneider, 344 Doctors Building, Cincinnati 2.

Get Your Banquet Tickets in Advance

In this issue is a page announcing the Annual Banquet and on it a coupon which may be used to order tickets in advance. Clip the coupon on page 365 and mail it with your check to the Columbus office, and receive your tickets before the meeting.

WEDNESDAY, APRIL 16

9:30 A. M.

JOINT SESSION
SECTION ON NERVOUS AND MENTAL DISEASES
SECTION ON PHYSICAL MEDICINE

Parlors A, B, C, D, Fourth Floor

This program for the joint session of the two sections was arranged by the following officers of the sections. George T. Harding, M. D., Worthington, Chairman, Arnold Allen, M. D., Dayton, Secretary, Section on Nervous and Mental Diseases; Ralph E. Worden, M. D., Columbus, Chairman, Richard D. Burk, M. D., Columbus, Secretary, Section on Physical Medicine. Program arranged in cooperation with the Ohio Psychiatric Association.

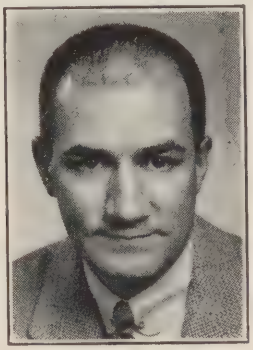
THE PARTICIPANTS

Richard D. Burk, M. D., Columbus, Medical Director, Ohio Rehabilitation Center.

J. R. Hodge, M. D., Cleveland, Clinical Instructor in Psychiatry, Western Reserve University School of Medicine.

Edward H. Lambert, M. D., Rochester, Minn., Associate Professor of Psyiology in Mayo Foundation, Graduate School, University of Minnesota.

Guest Participant



E. H. Lambert, M. D.
Rochester, Minn.

Henry D. Lederer, M. D., Cincinnati, Associate Professor of Psychiatry, University of Cincinnati College of Medicine.

Charles Long II, M. D., Cleveland, Assistant Professor of Physical Medicine and Rehabilitation, Western Reserve University School of Medicine.

Paul A. Nelson, M. D., Cleveland, Head of Department of Physical Medicine and Rehabilitation, Cleveland Clinic Foundation.

W. Donald Ross, M. D., Cincinnati, Associate Professor of Psychiatry, University of Cincinnati College of Medicine.

Franklin C. Shontz, Ph. D., Cleveland, Clinical Instructor in Psychology, Western Reserve University School of Medicine.

L. W. Sontag, M. D., Yellow Springs, Instructor in Psychiatry, University of Cincinnati College of Medicine.

John A. Whieldon, M. D., Columbus, Assistant Professor, Department of Psychiatry, Ohio State University College of Medicine.

Presiding: Dr. Worden.

9:30 **Physical and Psychiatric Aspects of Rehabilitation** (Panel Discussion)
Moderator: Dr. Ross.
Members of Panel: Drs. Burk, Lederer, Nelson and Whieldon.

10:30 **Electromyography and Related Techniques in the Diagnosis of Neuro-Muscular Diseases**—Dr. Lambert.

11:00 Recess for Tour of Exhibits.

11:30 **Personality as a Determinant of Performance**—Dr. Sontag.

11:50 **Preliminary Study of the Effect of Marsilid in the Treatment of Chronically Ill Patients**—Drs. Hodge and Shontz.

12:10 **An Optimistic Approach to Severe Disability**—Dr. Long.

12:30 Election of Officers for 1959.

WEDNESDAY, APRIL 16

9:30 A. M.

SECTION ON NEUROLOGICAL SURGERY

Parlors L-M, Fourth Floor

Chairman....Thomas A. Weaver, Jr., M. D., Dayton
Secretary.....Nathaniel R. Hollister, M. D., Dayton

THE PARTICIPANTS

William F. Collins, Jr., M. D., Cleveland, Assistant Professor of Neurosurgery, Western Reserve University School of Medicine.

W. J. Gardner, M. D., Cleveland, Chief, Department of Neurological Surgery, Cleveland Clinic Foundation.

William E. Hunt, M. D., Columbus, Assistant Professor of Neurosurgery, Ohio State University College of Medicine.

Curwood R. Hunter, M. D., Cincinnati, Clinical Instructor in Surgery, Division of Neurosurgery, University of Cincinnati College of Medicine.

Frank H. Mayfield, M. D., Cincinnati, Chairman, Department of Neurosurgery, Christ Hospital and Good Samaritan Hospital.

Max T. Schnitker, M. D., Toledo, Chief, Department of Neurosurgery, St. Vincent's Hospital.

9:30 **Involuntary Movement and Its Surgical Treatment** (Panel Discussion)
Moderator: Dr: Hunter.
Anatomy and Physiology of the Basal Ganglia Area—Dr. Hunt.
Historical Review of the Extrapyramidal Diseases—Dr. Collins.
Chemopallidectomy for Hemiballismus—Dr. Schnitker.
Dystonia Musculorum Deformans—Dr. Gardner.

10:50 Recess for Tour of Exhibits.

11:30 Continuation of Panel Presentation.
Risks Versus Advantages of Operation on the Globus Pallidus—Dr. Mayfield.

12:00 Discussion Period.

12:20 Election of Officers for 1959.

WEDNESDAY, APRIL 16

9:30 A. M.

SECTION ON OPHTHALMOLOGY

Parlors N-O, Fourth Floor

Chairman.....Roscoe J. Kennedy, M. D., Cleveland
Secretary.....Jacob Moses, M. D., Columbus

THE PARTICIPANTS

William H. Havener, M. D., Columbus, Associate Professor of Ophthalmology, Ohio State University College of Medicine.

Irving H. Leopold, M. D., Philadelphia, Pa., Professor and Head of Department of Ophthalmology, The Graduate School of Medicine, University of Pennsylvania.

Donald J. Lyle, M. D., Cincinnati, Professor of Ophthalmology, University of Cincinnati College of Medicine.

John L. Roberts, M. D., Toledo, Director of Ophthalmology, St. Vincent's Hospital.

Benjamin J. Wolpaw, M. D., Cleveland, Associate Surgeon, St. Luke's Hospital.

9:30 **Glaucoma Therapy**—Dr. Leopold.

10:30 Written questions to be answered by the guest speaker.

10:45 Election of officers for 1959.

11:00 Recess for Tour of Exhibits.

11:30 **Cataract Management**

Medical Management of the Cataract Patient—Dr. Wolpaw.

Pre-operative Preparation and Evaluation of the Cataract Patient—Dr. Havener.

Surgical Management of the Uncomplicated and Complicated Cases—Dr. Lyle.

Management of Complications of Cataract Extractions—Dr. Roberts.

WEDNESDAY, APRIL 16

10:00 A. M.

WORKSHOP ON MEDICAL WRITING

Parlors E-F, Fourth Floor

Conducted by Jonathan Forman, M. D., Columbus, Editor, *The Ohio State Medical Journal.*

All Annual Meeting registrants are invited to participate. Special attention will be given to *The Ohio State Medical Journal.* There will be discussion of collecting material; choosing a title; drafting an outline; the value of rewriting; the use of statistics; the use of and verification of references; summary and conclusions.

Technical Exhibits

A feature of the Annual Meeting will be the elaborate display of Technical Exhibits. Pharmaceutical and other supply houses will show latest developments in their respective fields and will have on hand detail men to discuss them with physicians.

WEDNESDAY, APRIL 16

2:00 P. M.

OHIO PSYCHIATRIC ASSOCIATION

Parlors A, B, C, D, Fourth Floor

President..George T. Harding, M. D., Worthington
Secretary-Treasurer....Arnold Allen, M. D., Dayton

THE PARTICIPANTS

John B. S. Campbell, M. D., Cincinnati, Assistant Clinical Professor of Neurology, University of Cincinnati College of Medicine.

Eugene E. Elder, M. D., Youngstown, Superintendent, Woodside Receiving Hospital.

H. D. Fabing, M. D., Cincinnati, Chief, Neuropsychiatric Service, Christ Hospital.

J. Robert Hawkins, M. D., Cincinnati, Instructor of Psychiatry, University of Cincinnati College of Medicine.

William E. Hillard, M. D., Cincinnati, Neuropsychiatrist, Cincinnati General and Christ Hospitals.

F. A. King, Ph. D., Columbus, Assistant Professor of Psychiatry, Ohio State University College of Medicine.

Judson S. Millhon, M. D., Cincinnati, Resident in Neurology, Cincinnati General Hospital.

James A. L. Moulton, M. D., Cincinnati, Member, American Psychiatric Association.

James L. Sagebiel, M. D., Senior Attending Neuropsychiatrist, Miami Valley Hospital.

Laurence M. Weinberger, M. D., Cuyahoga Falls, Senior Attending Neurosurgeon, City, Children's, St. Thomas Hospitals, Akron.

W. Zeman, M. D., Columbus, Assistant Professor of Pathology and Psychiatry, Ohio State University College of Medicine.

2:00 **My Observations of the Ohio Receiving Hospital System**—Dr. Elder.

2:20 **The Use of Marsilid in Acute Depressive States**—Drs. Fabing, Hawkins, Moulton and Hillard.

2:40 **The Treatment of Multiple Sclerosis with Galactose** — Drs. Millhon and Campbell.

3:00 **Periodic Paralysis Associated with Hyperthyroidism**—Dr. Moulton.

3:20 **Tumors of the Septum Pellucidum and Adjacent Structures with Abnormal Affective Behavior**—Drs. Zeman and King.

3:40 **The Use of Pre-Frontal Lobotomy (Grantham Technic) in Chronic Neuroses and Psychoses**—Dr. Sagebiel.

4:00 **Thermolobotomy**—Dr. Weinberger.

4:30 Business Meeting.

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Cocktail Party For Psychiatrists

The Cincinnati Society of Neurology and Psychiatry will have a cocktail party for members of the Ohio Psychiatric Association on Wednesday, April 16, from 5:00 to 7:00 P. M. in Parlor H, Fourth Floor, Netherland Hilton Hotel.

WEDNESDAY, APRIL 16

2:00 P. M.

GENERAL SESSION

Pavillon Fourth Floor

THE PARTICIPANTS

F. J. L. Blasingame, M. D., Chicago, Ill., Executive Vice-President, American Medical Association.

Irving H. Leopold, M. D., Philadelphia, Pa., Professor and Head of Department of Ophthalmology, The Graduate School of Medicine, University of Pennsylvania.

Irvine H. Page, M. D., Cleveland, Director of Research, Cleveland Clinic Foundation.

Edith L. Potter, M. D., Chicago, Ill., Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago, the School of Medicine.

Presiding: Maurice A. Schnitker, M. D., Toledo, Member, Committee on Scientific Work.

2:00 **It's Your AMA**—Dr. Blasingame.

2:30 **The Treatment of Hypertension**—Dr. Page.

3:00 Recess for Tour of Exhibits.

3:30 **Unfruitful Pregnancy**—Dr. Potter.

4:00 **Ophthalmoscopic Findings in Relation to General Medicine**—Dr. Leopold.

4:30 **The Doctor Defendant**

Second in the series of films on "Medicine and the Law" sponsored by the American Medical Association and American Bar Association and produced by the The Wm. S. Merrell Co., Cincinnati. The film deals with the prevention of professional liability action. It presents four case reports of situations which resulted in claims against physicians. The first film of the series, "The Medical Witness," was presented at a general session at the 1957 OSMA meeting in Columbus.

International Surgeons Congress To Consider GP Problems

The 11th biennial International Congress of the International College of Surgeons will be held in conjunction with the 23rd annual Congress of the United States and Canadian Sections (North American Federation) in Los Angeles, March 9-14.

An innovation of the meeting will be a surgical emergencies panel to which members of the American Academy of General Practice are invited. Dr. Ross T. McIntire of Chicago, executive director of the International College of Surgeons and former surgeon general of the U. S. Navy, will be the moderator.

Guest Participants



F. J. L. Blasingame, M. D.
Chicago



Irving H. Leopold, M. D.
Philadelphia

WEDNESDAY, APRIL 16

7:30 P. M.

ANNUAL BANQUET AND DANCE

Pavillon, Fourth Floor

Introduction of Officers and Councilors.
Introduction of Distinguished Guests.

Guest Participant

Address by David B. Allman, M. D., Atlantic City, President, American Medical Association.



David B. Allman, M. D.
Atlantic City

Entertainment.

Reception for Dr. Allman, Parlors L, M, N, and O.

Dancing until 1:00 A. M.

Tickets for the Annual Banquet at $7.50 each may be purchased by mail before the meeting from the Headquarters Office of the Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Tickets also may be purchased after the meeting has started at the Registration Headquarters, Fourth Floor Foyer, Netherland Hilton Hotel, Cincinnati.

SEE PAGE 365 FOR MORE BANQUET DETAILS

Hotel Reservations

Be sure and make your hotel reservations well in advance of the Annual Meeting. In this issue page 350 gives prevailing rates for accommodations in downtown Cincinnati hotels; also a coupon for convenient mailing to the hotel of choice.

Relax, Doctor!

Here's a Well-Earned Respite
For You and Your Lady

Top Entertainment

At the Annual Banquet



Sondra and Jon Steele

Song stylists Sondra and Jon Steele will combine music and charm when they step onto the floor at the Netherland Hilton Pavillon. Here's a cue to their stature in the entertainment field—their record, "My Happiness," sold well over a million and is still a popular number.

One of the most beautifully gowned girls in the entertainment field, Sondra will charm you with her solo numbers and her close harmony with Jon. Their repertoire of captivating melodies is enhanced by special arrangements written especially for their style by Jon.

This entertainment comes after a tasty meal served by the Netherland Hilton whose caterers are the best in the country.



Soft music during the dinner hour will come from the Howard Early Trio.

Heading the list of distinguished guests at the Banquet will be Dr. David B. Allman, President of the American Medical Association, who will be accorded the honor of a reception.

An Evening of Dancing will complete the festive occasion, to the accompaniment of the Clyde Trask Orchestra.

Tickets are on a first-come-first-served basis. Better order your tickets now and be sure.

Order Tickets Now for the Annual Banquet

The Ohio State Medical Association
79 E. State Street, Columbus 15, Ohio

Send me ..... tickets at cost of $7.50 each for the Annual Banquet, Ohio State Medical Association, Wednesday, April 16, Netherland Hilton Hotel, Cincinnati.

(Check, payable to the Ohio State Medical Association, for total cost of tickets ordered, must accompany order.)

Name (Please Print) .....

Street..... City and Zone.....

THURSDAY, APRIL 17

8:00 A. M.

HOUSE OF DELEGATES

COMPLIMENTARY BREAKFAST FOR MEMBERS OF THE HOUSE OF DELEGATES TO BE FOLLOWED BY THE FINAL BUSINESS SESSION

Parlors L, M, N, O, Fourth Floor

ORDER OF BUSINESS

Report of Committee on Credentials.

Consideration of unfinished business.

Reports of Reference Committees.
President's Address.
Resolutions.

Election of President-Elect. Nominations from the floor.

Report of Committee on Nominations:

(a) Nominations for The Council.

(Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.)

To be elected:

First District—(Incumbent, Frank H. Mayfield, M. D., Cincinnati, elected at 1957 Annual Meeting to fill the remaining year of the unexpired term of Dr. C. T. Atkinson, Middletown, resigned.)

Third District—(Incumbent, James R. Jarvis, M. D., Van Wert.) (Ineligible for re-election, having served the maximum time on The Council as provided in the Constition and By-Laws of the Association.)

Fifth District—(Incumbent, George W. Petznick, M. D., Shaker Heights.)

Seventh District—(Incumbent, Robert E. Hopkins, M. D., Coshocton.)

Ninth District — (Incumbent, Carter L. Pitcher, M. D., Portsmouth.)

Eleventh District—(Incumbent, H. T. Pease, M. D., Wadsworth.)

(b) **Election of Treasurer for a term of three years.** (Incumbent, Geo. J. Hamwi, M. D., Columbus. Eligible for re-election for one more term.)

(c) **Election of Delegates and Alternates to the American Medical Association**—four Delegates and four Alternates to be elected, each for a two-year term starting January 1, 1959, in compliance with the Constitution and By-Laws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1958, and they may be considered by the nominating committee for re-election for two-year terms starting January 1, 1959:

Charles L. Hudson, M. D., Cleveland
(Delegate)
C. E. Hufford, M. D., Toledo
(Alternate)
Carl A. Lincke, M. D., Carrollton
(Delegate)
H. M. Platter, M. D., Columbus
(Alternate)
George A. Woodhouse, M. D., Pleasant Hill
(Delegate)
R. Dean Dooley, M. D., Dayton
(Alternate)
Herbert B. Wright, M. D., Cleveland
(Delegate)
Fred W. Dixon, M. D., Cleveland
(Alternate)

Installation of officers for 1958-1959.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

Adjournment.

Greater Cincinnati Hospital Council Appoints Executive Secretary

Jerry N. Ransohoff, Cincinnati newspaperman and former medical editor of the *Cincinnati Post* for nine years, has been appointed executive secretary of the newly reorganized Greater Cincinnati Hospital Council.

Increased need for closer coordination of civil defense and disaster planning, desirability of unified recruiting and public relations programming, and the need for a common approach to various community health problems prompted 18 hospitals to reorganize the existing Superintendents' Council. Hospitals in a seven-county area in Ohio, Kentucky and Indiana, comprising greater Cincinnati, are now eligible for membership.

Offices of the council have been set up at 2212 Victory Parkway, Cincinnati 6, Ohio.

Sister Eugene Marie, administrator of Good Samaritan Hospital, Cincinnati, is president of the council.

Carl Cohen, Ph. D., has joined the staff of Battelle Memorial Institute, Columbus, where he will direct a newly organized cancer chemotherapy laboratory in the Institute's Biosciences Division. In that laboratory chemical agents will be evaluated for their effect upon animal cancers.

THURSDAY, APRIL 17

8:30 A. M.

REGISTRATION

Fourth Floor Foyer

9:00 to 9:30

TOUR OF EXHIBITS

THURSDAY, APRIL 17

10:00 A. M.

GENERAL SESSION

Pavillon, Fourth Floor

THE PARTICIPANTS

Henry A. Brunsting, M. D., Toledo, Director, Department of Dermatology, Maumee Valley Hospital.

Harold E. Harris, M. D., Cleveland, Chief, Department of Otolaryngology, Cleveland Clinic.

John R. Haserick, M. D., Cleveland, Head of Department of Dermatology, Cleveland Clinic.

Eldred B. Heisel, M. D., Columbus, Associate Professor of Medicine (dermatology), Ohio State University College of Medicine.

Orrin C. Keller, M. D., Toledo, Fellow, American College of Surgeons.

John C. Markley, M. D., Gallipolis, Chief, Department of Medicine, Holzer Hospital.

Frank H. Mayfield, M. D., Cincinnati, Chairman of the Department of Neurosurgery, Christ Hospital and Good Samaritan Hospital.

Harry A. Nieman, M. D., Dayton, Senior Dermatologist, Miami Valley Hospital.

James L. Sagebiel, M. D., Dayton, Senior Attending Neuropsychiatrist, Miami Valley Hospital.

Thomas G. Skillman, M. D., Columbus, Assistant Professor of Medicine, Department of Endocrinology and Metabolism, Ohio State University College of Medicine.

Alfred L. Weiner, M. D., Cincinnati, Assistant Professor of Dermatology, University of Cincinnati College of Medicine.

Presiding: A. Carlton Ernstene, M. D., Cleveland, Chairman, Committee on Scientific Work.

10:00 **The Treatment of Common Dermatological Problems**
Moderator: Dr. Weiner.
Members of Panel: Drs. Brunsting, Haserick, Heisel and Nieman.

11:00 Recess for Tour of Exhibits.

11:30 **What's New?**

In Pseudomembranous Enterocolitis—Dr. Markley.

In the Treatment of Parkinsonism—Dr. Mayfield.

In the Treatment of Deafness—Dr. Harris.

In the Treatment of Schizophrenia—Dr. Sagebiel.

In the Treatment of Diabetes Mellitus—Dr. Skillman.

In the Treatment of Thermal Burns—Dr. Keller.

THURSDAY, APRIL 17

2:00 P. M.

GENERAL SESSION

Pavillon, Fourth Floor

THE PARTICIPANTS

H. W. Clatworthy, Jr., M. D., Columbus, Associate Professor of Surgery, Ohio State University College of Medicine.

Benjamin Felson, M. D., Cincinnati, Professor and Director, Department of Radiology, University of Cincinnati College of Medicine.

Donald M. Glover, M. D., Cleveland, Clinical Professor of Surgery, Western Reserve University School of Medicine.

Frank J. Rack, M. D., Cleveland, Assistant Professor of Surgery, Western Reserve University School of Medicine.

F. A. Simeone, M. D., Cleveland, Professor of Surgery, Western Reserve University School of Medicine.

Presiding: A. Carlton Ernstene, M. D., Cleveland, Chairman, Committee on Scientific Work.

2:00 **The Acute Abdomen** (Panel Discussion)
Moderator: Dr. Simeone.
Principles of Diagnosis—Dr. Glover.
The Roentgenogram in Diagnosis and Management—Dr. Felson.
Principles of Diagnosis and Treatment of Small Intestinal Obstruction—Dr. Rack.
Appendicitis in Infancy and Childhood—Dr. Clatworthy.

2:45 Discussion Period.

3:30 Adjournment.

Jefferson Medical Alumni Reunion Scheduled Tuesday, April 15

A get-together has been arranged for alumni of Jefferson Medical College, their wives and guests who will be in attendance at the 1958 Annual Meeting of the Ohio State Medical Association, Cincinnati, April 15-17. It will be held at Town and Country, 1622 Dixie Highway, Covington, Ky. (15 minutes by taxi from Cincinnati.) The event will begin with a social hour at 6 o'clock followed by dinner at 7:30, and "short speeches" about "Jeff" at 8:30. Those who plan to attend may assist the committee on Arrangements by notifying the chairman: Dr. Robert J. Anzinger, 4125 Hamilton Avenue, Cincinnati 23.

SCIENTIFIC AND EDUCATIONAL EXHIBITS

The Scientific and Educational Exhibits in the South Hall, Fourth Floor, will be open from 9:00 A. M. to 5:30 P. M. on Tuesday, April 15, and Wednesday, April 16; and from 9:00 A. M. to 3:30 P. M. on Thursday, April 17.

Obstructive Lesions of the Duodenum Distal to the Bulb
William C. Strittmatter, M. D., and Charles H. Brown, M. D., Cleveland Clinic Foundation.

Family Doctor's Bag
Southwestern Ohio Society of General Physicians.

Changing Pattern of Leukemia—225 Cases Observed 1937-1957
C. S. Higley, M. D., W. C. Stoner, Jr., M. D., D. A. Baumgartner, M. D., and Jack Berman, M. D., Saint Luke's Hospital, Cleveland.

The Hamman-Rich Syndrome (Fibrosing Interstitial Pneumonitis)
H. S. Van Ordstrand, M. D., W. R. Biddlestone, M. D., L. J. McCormack, M. D., and V. E. Reinking, M. D., Cleveland Clinic.

Valvular Lesions of the Heart; Modern Methods of Surgical Management
E. R. Maurer, M. D., and F. L. Mendez, Jr., M. D., Cincinnati.

Adventures in Cinefluorography
Robert S. Green, M. D., Erna Borousch, M. D., F. L. Mendez, M. D., Memorial Heart Laboratory, Cincinnati.

Placenta Accreta, Increta and Percreta
Howard P. Taylor, M. D., J. J. Cahill, M. D., W. A. Hawk, M. D., Cleveland Clinic.

Clinico-Pathological Observations on the Fate of Arterial Freeze-Dried Homografts
W. A. Hawk, M. D., A. W. Humphries, M. D., Cleveland Clinic Foundation.

Chronic Pancreatitis
Stanley O. Hoerr, M. D., and Harold E. Dunlap, M. D., Cleveland Clinic.

Prediction and Treatment of Threatened Abortion
R. R. Schwalenberg, M. D., and T. D. Efstation, M. D., Tiffin.

Eyelid Reconstruction with Full Thickness Graft Following Traumatic or Surgical Deformity of the Eyelids
Byron E. Boyer, M. D., and Mary M. Martin, M. D., Cincinnati.

Prevention of Inverted Navels
James R. Jarvis, M. D., Van Wert.

Clinical Experiences with Triiodothyronine
Wm. F. Bradley, M. D., Central Ohio Foundation for Medical Education and Research, Columbus.

Premature Care
Edward A. Wagner, M. D., Daniel V. Jones, M. D., Carl A. Koch, M. D., University of Cincinnati College of Medicine, Department of Pediatrics and The Premature Service, Cincinnati General Hospital.

Safe Surgical Exposure of the Facial Nerve Using Skeletal Anatomy
Stephen P. Hogg, M. D., Robert C. Kratz, M. D., Department of Otolaryngology, University of Cincinnati College of Medicine.

Headache—Diagnosis—Treatment
Raymond L. Hilsinger, M. D., Cincinnati General Hospital, Christ Hospital, Cincinnati.

Normal and Pathological Blood Smear
Miami Valley Hospital, School of Medical Technology, Dayton.

Chemotherapy in Rheumatoid Arthritis
Arthur L. Scherbel, M. D., and John W. Harrison, M. D., Cleveland Clinic.

Light and Electronics in Laboratory Medicine
Walter H. Hartung, Jr., M. D., Department of Pathology, St. Charles Hospital, Toledo.

A Two-Stage Approach to Ventricular Septal Defects with Severe Pulmonary Hypertension
Howard D. Sirak, M. D., Don M. Hosier, M. D., The Cardiovascular Service of the Ohio State University Health Center and the Children's Hospital, Columbus.

Bronchogenic Cysts in Patients Presumed To Have Pulmonary Tuberculosis
Neil C. Andrews, M. D., A. J. Christoforidis, M. D., and Philip C. Pratt, M. D., Ohio Tuberculosis Hospital, Ohio State University.

Left Heart Catheterization
Charles V. Meckstroth, M. D., Richard Booth, M. D., Hugh Hull, M. D., and Edward Neff, M. D., Ohio State University Hospital.

The Drop-Latex Fixation Test for Rheumatoid Arthritis
Norman O. Rothermich, M. D., Francis W. McCoy, M. D., Melvin S. Rheins, Ph. D., and Vol K. Philips, M. D., Ohio State University.

Ultra-Fine Structure of Cells

Walter J. Frajola, Ph. D., Bertha A. Bouroncle, M. D., and Marie H. Greider, Herman A. Hoster Research Laboratory, Ohio State University.

Splenectomy in Hypersplenism—A Twenty-Five Year Experience

Charles A. Doan, M. D., Bruce K. Wiseman, M. D., and Bertha A. Bouroncle, M. D., Ohio State University.

Air Embolism—Clinical Diagnosis and Prevention of Fatalities

John R. Jones, M. D., J. J. Jacoby, M. D., J. Ziegler, M. D., J. Siddall, M. D., Department of Surgery (Anesthesia), Ohio State University Hospital.

Surgical Correction of Acquired Heart Disease —Open Versus Closed Techniques

Earle B. Kay, M. D., D. Mendelsohn, M. D., Thomas MacKrell, M. D., and H. A. Zimmerman, M. D., St. Vincent Charity Hospital, Cleveland.

Combined Dermatologic and Psychiatric Study of a New Tranquilizer

Jay Shanon, M. D., Departments of Dermatology and Psychosomatic Service, Department of Psychiatry, University of Cincinnati College of Medicine.

Constructive Surgery in the Newborn

Robert H. Whittlesey, M. D., Donald M. Glover, M. D., Richard G. Hodges, M. D., Departments of Surgery and Pediatrics, St. Luke's Hospital, Cleveland.

Clinical Electromyography

Richard D. Burk, M. D., Ernest W. Johnson, M. D., Division of Physical Medicine and Rehabilitation, Department of Medicine, Ohio State University College of Medicine.

Opportunities for Training in Anesthesia

J. J. Jacoby, M. D., and William Hamelberg, M. D., Columbus; American Society of Anesthesiology, Committee on Postgraduate Education.

Tuberous Sclerosis and Renal Angiomyolipoma

Jack N. Taylor, M. D., Department of Urology, Ohio State University College of Medicine, Columbus.

Congenital Heart Lesions: Diagnosis and Surgical Correction

F. S. Cross, M. D., H. F. Inderlied, M. D., F. A. Oldenburg, M. D., St. Luke's Hospital, Cleveland.

Carcinoma of the Esophagus and Cardia

Maurice G. Buckles, M. D., Richard J. Lescoe, M. D.; Benjamin Franklin Hospital and Mt. Carmel Hospital, Columbus.

Demonstration of Chronic Bronchitis at Bronchography

Atis K. Freimanis, M. D., William Molnar, M. D., Thomas R. Frye, M. D., Department of Radiology, Ohio State University Hospital.

Soft Tissue Malignancy in Childhood: a Diagnostic Problem

Robert J. Izant, Jr., M. D., Wm. H. R. Howard, M. D., H. Wm. Clatworthy, Jr., M. D., Department of Pediatric Surgery, The Ohio State University College of Medicine; Children's Hospital, Columbus.

Management of Oral Cancer

Henry LeClaire, M. D., and E. L. Saenger, M. D., Cincinnati.

The Treatment of Iron Deficiency States with Intramuscular Iron

Harold S. Schiro, M. D., Cincinnati.

A Stepchild of Cerebral Angiography, Vertebral Angiograms of the Brain, Showing Space Relations of Typical Lesions in Different Views

H. F. Plaut, M. D., Radiology Service, Veterans Administration Center, Dayton, and Ohio State University, Columbus.

Accident Prevention and Poison Control

Paul A. Hayden, Assistant Administrator, Akron Children's Hospital; John Norman, M. D., Akron, State Chairman, Accident Prevention Committee, American Academy of Pediatrics.

Coordinator-Services for Preschool Blind Children

Coordinator-Services for Preschool Blind Children, Division of Social Administration, Ohio Department of Public Welfare, Columbus.

Cancer of the Cervix

American Cancer Society, Ohio Division, Inc., Cleveland.

Research-Rehabilitation

Ohio Society for Crippled Children, Inc. Columbus.

Horizons in Mental Retardation

Hamilton County Diagnostic Clinic for the Mentally Retarded, Cincinnati.

Sacrococcygeal Teratomas

Lester W. Martin, M. D., University of Cincinnati College of Medicine and Children's Hospital, Cincinnati.

TECHNICAL EXHIBITORS

Hall of Mirrors, Third Floor; North Hall, Fourth Floor

Open from 9:00 A. M. to 5:30 P. M. on Tuesday, April 15, and Wednesday, April 16; and from 9:00 A. M. to 3:30 P. M. on Thursday, April 17.

Exhibitor	Address	Booth No.
Abbott Laboratories	North Chicago, Ill.	35
Aloe, A. S., Company	St. Louis, Mo.	37-38
Ames Company, Inc.	Elkhart, Ind.	12
Arnar-Stone Laboratories, Inc.	Mount Prospect, Ill.	26
Audio-Digest Foundation	Glendale, Cal.	68
Ayerst Laboratories	Arlington, Va.	62
Baker Laboratories, Inc., The	Cleveland, Ohio	24
Burroughs Wellcome & Co. (U.S.A.) Inc.	Tuckahoe, N. Y.	43
Caldwell & Bloor Co., The	Mansfield, Ohio	69
Camp, S. H., & Company	Jackson, Mich.	3
Central Pharmacal Company, The	Seymour, Ind.	65
Ciba Pharmaceutical Products, Inc.	Summit, N. J.	41
Coca-Cola Company, The	Atlanta, Ga.	8
Columbus Hospital Supply Co.	Columbus, Ohio	9-10
Columbus Pharmacal Co., The	Columbus, O.	59
Davies, Rose & Company, Limited	Boston, Mass.	2
Desitin Chemical Company	Providence, R. I.	48
Dietene Company, The	Minneapolis, Minn.	72
Eaton Laboratories	Norwich, N. Y.	61
Fischer, H. G. & Co.	Franklin Park, Ill.	47
Fleet, C. B., Company, Inc.	Lynchburg, Va.	1
Fougera, E., & Co., Inc.	Hicksville, N. Y.	52
Freeman Manufacturing Company	Sturgis, Mich.	23
Gallagher-Roach & Company	Columbus, O.	11
Heinz, H. J., Company	Pittsburgh, Pa.	42
Holland-Rantos Co., Inc.	New York, N. Y.	33
Johnson & Johnson	New Brunswick, N. J.	49
Kremers-Urban Co.	Milwaukee, Wis.	44
Lederle Laboratories Division, American Cyanamid Co.	Pearl River, N. Y.	29
Lilly, Eli, and Company	Indianapolis, Ind.	27
Lippincott, J. B. Company	Philadelphia, Pa.	40
Lloyd Bros, Inc.	Cincinnati, Ohio	25
Lloyd, Dabney & Westerfield, Inc.	Cincinnati, Ohio	60
Loma Linda Food Company	Arlington, Cal.	46
Maico Company, Inc.	Cincinnati, Ohio c/o S. K. Foster & Associates	6
Massengill, S. E., Co.	Bristol, Tenn.	17
Mead Johnson & Company	Evansville, Ind.	21
Medco Products Co.	Tulsa, Okla.	77
Medical Protective Company, The	Fort Wayne, Ind.	5
Merck Sharp & Dohme, Div. of Merck & Co., Inc.	Philadelphia, Pa.	36
Merrell, Wm. S., Co., The	Cincinnati, O.	14
Miller Surgical Company	Chicago, Ill.	7
Milex-Alpha Products	Evanston, Ill.	74
Mueller, V., & Co.	Chicago, Ill.	22
Nepera Laboratories	Morris Plains, N. J.	76
Nusbaum, Hermien and Associates	Chicago, Ill.	64
Organon, Inc.	Orange, N. J.	51
Ortho Pharmaceutical Corporation	Raritan, New Jersey	16
Parke, Davis & Company	Detroit, Mich.	39
Pelton & Crane Company, The	Charlotte, North Carolina	75
Pfizer Laboratories	Brooklyn, N. Y.	66
Procter & Gamble Company, The	Cincinnati, Ohio	73
Purdue Frederick Co., The	New York, N. Y.	71
Robins, A. H., Company, Inc.	Richmond, Va.	4
Ross Laboratories	Columbus, Ohio	34
Sanborn Company	Waltham, Mass.	15
Sandoz Pharmaceuticals	Hanover, N. J.	32
Saunders, W. B., Company	Philadelphia, Pennsylvania	57
Schering Corporation	Bloomfield, N. J.	55
Schmid, Julius, Inc.	New York, N. Y.	45
Searle, G. D., & Co.	Chicago, Ill.	18
Smith, Carroll Dunham Pharmacal Company	New Brunswick, N. J.	53
Smith, Kline & French Laboratories	Philadelphia, Pa.	20
Squibb, E. R., & Sons, Division of Olin Mathieson Chemical Corp.	New York, New York	31
Stuart Company, The	Chicago, Ill.	54
Testagar & Co., Inc.	Detroit, Mich.	63
Tutag, S. J., & Co.	Detroit, Mich.	70
Upjohn Company, The	Kalamazoo, Mich.	13
U. S. Vitamin Corporation	New York, N. Y.	30
Wallace Laboratories	New Brunswick, N. J.	50
Warner-Chilcott Laboratories	Morris Plains, New Jersey	67
Warren-Teed Products Company	Columbus, Ohio	58
Wendt-Bristol Co., The	Columbus, Ohio	56
Winthrop Laboratories, Inc.	New York, New York	28
Wocher, Max, & Son Co., The	Cincinnati, Ohio	19

Programs of Health Organizations . . .

Ohio Cancer Conference and Annual Meeting of the Ohio State Heart Association Scheduled To Be Held in Cincinnati, Monday, April 14

TWO important programs of interest to physicians are scheduled in Cincinnati on the eve of the 1958 Annual Meeting of the Ohio State Medical Association. They are the 1958 Annual Ohio Cancer Conference Scheduled on Monday, April 14, beginning at 9:00 a. m.; and the Annual Meeting of the Ohio State Heart Association scheduled the same day from 2:00 to 4:30 p. m.

Ohio Cancer Conference

The Ohio Cancer Conference will be held in the Pavillon, fourth floor of the Netherland-Hilton Hotel. The program has been announced as follows:

William J. Flynn, M. D., Youngstown, chairman, presiding.

9:00 a. m. **Welcome**—Arthur G. James, M. D., Columbus, president, Ohio Division of the American Cancer Society.

9:10 **Tobacco and Lung Cancer**—William Alton Ochsner, M. D., New Orleans, La.

9:40 **Recent Trends in the Management of Breast Cancer;** a Panel Discussion—
Moderator: William A. Altemeier, M.D., Cincinnati.
Collaborators: Charles M. Barrett, M. D., Cincinnati; Cushman D. Haagensen, M. D., New York; Olof H. Pearson, M. D., New York; Jerome A. Urban, M. D., New York.

11:45 Intermission.

12:00 **Tumors of Childhood**—Harold W. Dargeon, M. D., New York.

12:30 p. m. Lunch.

2:00 **The Problem of Pigmented Moles and Malignant Melanomas**—George T. Pack, M. D., New York.

2:30 **The Management of the Patient with Advanced Cancer;** a Panel Discussion—
Moderator: Max M. Zinninger, M. D., Cincinnati.
Collaborators: Eugene M. Bricker, M. D., St. Louis; Laird Myers, M. D., New York; George T. Pack, M. D., New York; Eugene P. Pendergrass, M. D., Philadelphia.

Additional Data on Participants

Dr. Flynn is chairman of the Professional Education Committee, American Cancer Society, Ohio Division, and chief of the head and neck surgical service, Youngstown Hospital.

Dr. James, associate professor, Department of Surgery, OSU, and director of the Columbus Cancer Clinic.

Dr. Ochsner, professor of surgery, Tulane University, and director of general surgery, Ochsner Clinic and Ochsner Foundation Hospital, New Orleans.

Dr. Altemeier, professor and chairman, Department of Surgery, University of Cincinnati.

Dr. Barrett, professor of radiology-radiotherapy, University of Cincinnati.

Dr. Haagensen, professor of clinical surgery, Columbia University.

Dr. Pearson, Sloan-Kettering Institute for Cancer Research, New York.

Dr. Urban, Sloan-Kettering Institute for Cancer Research, New York.

Dr. Dargeon, chief of pediatric service, Memorial Center for Cancer and Allied Diseases, New York, and associate professor of clinical pediatrics, Cornell University.

Dr. Pack, attending surgeon, Memorial Cancer Center, New York, and clinical professor of surgery, New York Medical College.

Dr. Zinninger, professor of surgery, University of Cincinnati.

Dr. Bricker, associate professor of clinical surgery, Washington University.

Dr. Myers, assistant professor of medicine, Cornell University, and assistant attending physician, Memorial Center for Cancer and Allied Diseases, New York.

Dr. Pendergrass, director of the Department of Radiology and professor of radiology, University of Pennsylvania.

* * *

Ohio State Heart Association

The Annual Meeting of the Ohio State Heart Association will be held in the Sheraton Gibson Hotel, Cincinnati, Monday, April 14, from 2:00 to 4:30 p. m. Two programs are scheduled to run concurrently, the Scientific Session in the Ball Room; and the Community Health Session in the Sheraton Room. Subjects and speakers are as follows:

Scientific Session

Arteriosclerosis—

Moderator: Irvine H. Page, M. D., director of research, Cleveland Clinic Foundation, Cleveland.

(Continued on Next Page)

Participants: Edgar V. Allen, M. D., senior consultant, Mayo Clinic, Rochester, Minn.; Jules Hirsch, M. D., Rockefeller Institute for Medical Research and Hospital, New York City; Johnson McGuire, M. D., director, Cardiac Laboratory, College of Medicine, University of Cincinnati; Frederick J. Stare, M. D., Ph. D., Department of Nutrition, Harvard University, Boston, Mass.

There will be opportunity for questions and answers.

Community Health Session

Theme of Program: **Research—Everyone's Job.**

Highlights, American Heart Association Research—John H. Peters, M. D., Assistant medical director for research, American Heart Association, New York.

Highlights, National Heart Institute Research—James Watt, M. D., director, National Heart Institute, Bethesda, Md.

Research in Ohio — Walter Pritchard, M. D., Cleveland; George Morrice, Jr., M. D., Columbus; John Braunstein, M. D., Cincinnati.

Telling the Research Story—M. Frederick Arkus, public relations counsel, American Heart Association, New York City.

There will be opportunity for questions and answers.

Program Committee: John W. Martin, M. D., Cleveland, chairman; Dale P. Osborn, M. D., Cincinnati; A. B. Schneider, M. D., Cleveland.

Medical Societies, hospitals, etc., which are interested in obtaining names of psychiatric speakers, are invited to contact the G. P. Project, American Psychiatric Association, 1785 Massachusetts Ave., N. W., Washington 6, D. C. The project is jointly sponsored by the American Psychiatric Association and the American Academy of General Practice.

SS Administrator Charles Schottland told representatives of major national groups in health and welfare fields that, contrary to popular concept, social security is a tax rather than an insurance program in the usual sense.

Woman's Auxiliary Annual Meeting

SHERATON-GIBSON HOTEL,
CINCINNATI

APRIL 14, 15, 16, 17

(All sessions at the Sheraton-Gibson Hotel unless otherwise indicated.)

Chairman.....Mrs. Charles W. Hoyt, Cincinnati

Co-Chairman.....Mrs. Carl F. Schilling, Cincinnati

MONDAY, APRIL 14

Parlor I

9:00 A. M. Resolutions Committee.

Florentine Room Mezzanine

1:00 P. M. Registration.

Parlor H

1:00 P. M. Preconvention Board Meeting.

Parlor I

3:00 P. M. Opening Day Tea.

Parlors N, O, P, Q

6:00 P. M. Cocktail Party.

7:00 P. M. Dinner for Board Members.

Parlor H

8:30 P. M. Continuance of Board Meeting.

TUESDAY, APRIL 15

Florentine Room Mezzanine

8:30 A. M. Registration.

Parlors 4 and 5

9:00 A. M. Business Session.

Hotel Sinton Ballroom

12:00 Noon Doctors' Day Luncheon.

Parlors 4 and 5

2:30 P. M. School of Instruction.

WEDNESDAY, APRIL 16

Florentine Room Mezzanine

8:30 A. M. Registration.

Parlors 7, 8, 9

9:00 A. M. Business Session.

Sheraton-Gibson Ballroom

12:30 P. M. Ladies' Luncheon and Fashion Show.

Parlors 7, 8, 9

3:00 P. M. Business Session.

Netherland Hilton Hotel

7:30 P. M. Annual Banquet, Ohio State Medical Association.

THURSDAY, APRIL 17

Parlor H

10:00 A. M. Post-Convention Brunch — Board Members.

EFFECTIVE, DEPENDABLE THERAPY FOR VAGINITIS



Floraquin® eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported[2] trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

Floraquin effectively eradicates both trichomonal and monilial vaginal infections through the action of its Diodoquin® content. Floraquin also furnishes boric acid and sugar to restore the normal vaginal acidity which inhibits pathogens and favors the growth of protective Döderlein bacilli.

Pitt[1] recommends vaginal insufflation of Floraquin powder daily for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

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1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama *25*:182 (Feb.) 1956.
2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. *16*:570 (Dec.) 1955.

SEARLE

Hospital Departments . . .

Joint Commission on Accreditation Stresses Importance of Dietary Department and Emergency Room in Standard Equipment of Hospital

THE Joint Commission on Accreditation of Hospitals, in keeping with its aim of assisting hospitals to meet and exceed minimal standards of high quality patient care, stresses the importance of the dietary department and emergency room. These two departments are discussed in this article. A third department equal in importance is the hospital pharmacy or drug room which was discussed in the February issue.

EDITOR'S NOTE: At the 1957 Annual Meeting of the OSMA, the House of Delegates instructed *The Journal* to publish material on hospital accreditation. In previous issues, the following phases of the subject were discussed: August—principles underlying the work of the accreditation commission; September—recommendations of the AMA Stover Committee; October—medical staff meetings; November—medical records; December—responsibilities of the medical staff; January—clinical laboratory services; February—the hospital pharmacy. This is the eighth article in the series.

In subsequent articles as information is available *The Journal* will present suggestions and information from the Joint Commission and answers by the Commission to many varied questions on the activities of the Commission, standards set, hospital administrative problems, etc.

Dietary Department

In every instance specific local laws and ordinances should be obeyed. The Standards of the Commission in relation to this department are as follows:

a. There shall be an organized department directed by qualified personnel and integrated with other departments in the hospital.

b. Facilities shall be provided which meet the requirement of the local sanitary code for the storage, preparation, and distribution of food for the general dietary needs of the hospital. These shall include facilities for the preparation of special diets.

c. There shall be a qualified dietitian on full time or on a consultative basis and in addition, administrative and technical personnel competent in their respective duties.

d. There shall be a systematic record of diets, correlated with the medical records.

e. Departmental and interdepartmental conferences shall be held periodically.

It is the opinion of the Joint Commission that this department should be under the supervision of a qualified dietitian (preferably A. D. A. registered), on a full time basis if possible or in smaller hospitals on a consultative part-time basis. There should be facilities for preparing therapeutic diets, although this does not necessarily require a special diet kitchen. In visiting a hospital, the surveyor evaluates this department on the basis of cleanliness, proper and adequate refrigeration, dishwashing and garbage disposal facilities, safe practices in the preparation and transportation of food, and the controls established to insure proper diet therapy. The commonest faults reported by surveyors are listed:

1. Lack of thermometers and temperature controls in large refrigerators.

2. Lack of temperature and thermostatic controls on dishwashing apparatus and even when present, not utilized. Hand drying of dishes.

3. Poor and unsanitary garbage control and disposal.

4. Storage of uncovered food in the same refrigerator with drugs.

5. Failure to clean ice storage bins. This is quite frequently found.

6. Presence of unimaginative, unpalatable, repetitious, stereotyped special diets.

7. Poor housekeeping and sanitation in the department.

8. Uninstructed personnel in the handling, presentation and disposal of food.

9. Poor transportation of food, resulting in cold, unpalatable food.

Emergency Room

As hospitals have become more and more the focal point of medical care in a community, the services rendered by this department have gained importance. The Standards state that if a hospital maintains this service, and all hospitals except very specialized ones should, the following is necessary:

a. There shall be a well organized depart-

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Early effective therapy is provided against such bacterial complications as sinusitis, otitis, bronchitis and pneumonitis to which the patient may be highly vulnerable at this time.

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Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

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Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

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ment directed by qualified personnel and integrated with other departments of the hospital.

b. Facilities shall be provided to assure prompt diagnosis and emergency treatment.

c. There shall be adequate medical and nursing personnel available at all times.

d. Adequate medical records on every patient must be kept.

e. There shall be a written plan for the care of mass casualties and this plan should be coordinated with the in-patient and out-patient services of the hospital.

In several hospitals surveyed it has been noted that nurses are treating and prescribing for patients in the emergency room. No physician sees the patient. This is absolutely wrong. The hospital is guilty of wrongdoing by allowing a non-physician to practice medicine. Serious legal consequences could result.

Many hospitals are found with very poor emergency room records. Emergency room cases frequently become court or compensation cases. The good emergency room record should contain proper identification, short history of the disease or injury, physical findings, laboratory and x-ray reports if performed, record of treatment, prognosis and disposition of the case. This record must be authenticated by the physician rendering the service.

A plan, rehearsed at least twice a year, for the reception, care and evacuation of mass casualties is mandatory for all hospitals. It has been a requirement of the Joint Commission for two years. An unprepared hospital, in case of a community catastrophe, fails itself and fails its community. Hospitals not having a definite written rehearsed plan are strongly criticized by the Joint Commission.

Legal-Medical Institute Is Scheduled in Cleveland

Western Reserve University's Law-Medicine Center has scheduled the fourth in a series of institutes for April 25-26 on the University campus. Entitled "The Mind: A Law-Medicine Problem. Details may be obtained from Oliver C. Schroeder, Jr., director, Law-Medicine Center, Western Reserve University, Cleveland 6.

Dr. William S. Clark, associate professor of medicine at Western Reserve University, Cleveland, has been named director of the Department of Patient Care, National Foundation for Infantile Paralysis with headquarters in New York. He will assume his new post early in the summer.

Dermatological Society Organized In the Cincinnati Area

The Noah Worcester Dermatological Society is a new organization formed by the Department of Dermatology of the University of Cincinnati College of Medicine to sponsor scientific meetings and foster reunions of former residents and fellows, members of the faculty and members of the Cincinnati Dermatological Society. In view of the widespread geographic distribution of former residents and fellows annual meeting will be held in areas other than Cincinnati.

Both the meetings of the Noah Worcester Dermatological Society and membership in the Society will be open to graduate dermatologists, residents and fellows in dermatology and graduate degree scientists in other fields, regardless of any association, past or present with the University of Cincinnati.

The organization and founders meeting of the Noah Worcester Dermatological Society will be held at Eden Roc Hotel, Miami Beach, Florida, April 23 through April 27. Both executive and scientific sessions are planned.

The organization committee for the new society consists of Drs. Donald Birmingham, Mitchell Ede, Leon Goldman, Edwin Higgins, Daniel Kindel, H. Jerry Lavender, Harry Nieman, Robert Preston, John Squires, Raymond Suskind, and Alfred Weiner, Chairman.

Program for Medical Section, Ohio Academy of Science Announced

The Annual Meeting of the Ohio Academy of Science will be held in Akron, April 10-12. The Medical Section of this academy has arranged a program for Friday, April 11, starting at 9 a. m.

The following subjects to be discussed by a team from the Ohio State University College of Medicine have been announced: Antithrombin in human plasma, effects of intra-abdominal pressure on respiration and the cardiovascular system, education in science, bile in the etilology of acute pancreatitis, changes in gastric physiology following gastric surgery, the conservative treatment of gastric ulcer, pulmonary function before and after thoracic surgery, left heart catheterization, bronchogenic cysts simulating tuberculous cavities, environmental influences on acetabular development, and other topics.

Additional information may be obtained by writing to Karl P. Klassen, M. D., chief of the Division of Thoracic Surgery, Ohio State University Health Center, Columbus 10.

Are You Eligible To Vote . . .

Primary Election Day Is May 6, But An Equally Important Date for Many Citizens Is March 26—Deadline for Registration Where It Is Required

YOUR franchise may be at stake. If you live in a registration district and are not registered, you have until March 26 to qualify yourself to vote in the May 6 Primary Elections.

The Primary Elections set the stage for the General Election on November 4. They are, therefore, all-important to physicians, members of their families and friends who feel a devotion to civic responsibility.

Registration is a simple matter. Here are the points to be remembered, presented in question and answer form from information furnished by Ted W. Brown, Secretary of State:

What is the registration deadline?

Forty days before the Primary Election, or March 26.

Who must register?

Every citizen who resides in a "registration district" must be registered with his county Board of Elections before he is eligible to vote.

What is a registration district?

The county Board of Elections must maintain a registration of eligible voters in every city of 16,000 population or over. Municipalities of less than 16,000 population may elect to maintain registration. The Board of Elections of a county may require registration in the entire county or in certain precincts. A registration district, therefore, may be a county, a municipality, a group of precincts or a single precinct.

How does a person know whether he is in a registration district or in a non-registration area?

If he resides in a municipality of 16,000 population or over, he must be registered. If he resides in a suburban community, a small municipality or a rural area, and is in doubt, he should phone the county Board of Elections and ask.

Under what conditions must a person re-register?

Registration is permanent, subject to the following exceptions:

a. If the citizen has not voted in a general, primary or special election since January 1, 1956, he must register again.

b. If the citizen has changed name—e. g., if a woman has married—she must re-register. If a woman marries between March 26 and May 6, she may vote on May 6 under her former name.

c. A veteran of the armed services must register after he is discharged.

d. A voter who changes his place of residence from one county to another, must register with the Board in the county to which he moves if his new residence is in a registration precinct. A voter who changes his residence to a new address within a registration district must notify his Board of Elections of such change. Some boards require the voter to present himself in person; others accept written notice.

What is the procedure for voters in non-registration areas?

In precincts not in registration districts, citizens are automatically eligible to vote. A voter may be required at the polling booth to produce evidence to the satisfaction of the election judge, or under oath, that he is qualified to vote.

What is the residence requirement for registration?

A person who will have met the residence requirement for voting by May 6—that is, will have lived in the State one year, in the county and precinct 40 days, and is otherwise qualified to vote—may register on or before March 26.

If he has moved his residence between March 26 and Election Day, what can he do?

Vote at the precinct from which he moved.

If a citizen has moved or is planning to move prior to March 26, may he vote at the precinct in which he formerly resided?

No. If he does not qualify himself to vote in the new precinct by notifying the Board of change of address, he will have lost his privilege of voting on May 6.

Suppose he moves his residence on March 25?

He will have been in the new precinct for 40 days by Election Day and, therefore, may register immediately.

If a citizen in a registration district will reach his 21st birthday between March 26 and November 4 (date of the General Election), may he register?

Yes, he may register on or before March 26 and vote for candidates in the Primary Elections.

If a person who resides in a non-registration

area will be 21 years old on or before November 4, what is the procedure?

If he meets other requirements of a voter, he will automatically become eligible to vote for candidates in the Primaries.

Where does one register?

At the headquarters of the Board of Elections of county of residence or at polling places indicated by the Board.

Where does a student register?

In most cases in the county in which he maintained residence just prior to entering the institution of learning.

How does a disabled person register?

A voter who is prevented by sickness or physical disability from registering in person may apply to his county Board of Elections by mail or phone for registration forms. The application must state the facts as to the voter's disability. Both the registration forms and a declaration of the facts as to disability must be notarized, and both must be delivered to the Board of Elections by a reliable and responsible person. Some boards require this person to be a notary public.

What about persons in the armed forces?

Persons who are residents of a registration district and who are in active service in the armed forces, and are otherwise qualified to vote, may cast absentee ballots without previous registration.

Does this privilege extend to civilians who will be away from home on May 6?

No. Students and other persons who must be registered in order to vote and who plan to be away on May 6 should register now so that they will be eligible to cast absentee ballots.

Absentee Voting

Persons who will be away from home on May 6 should plan to cast absentee votes. Here are some dates to remember and other data on absentee voting:

Civilians who wish to cast absentee ballots must be qualified to vote the same as though they were voting at home; e. g., they must be registered if they live within a registration area.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail ballots which are to be properly filled out and returned in accompanying "identification" envelopes.

Ohioans who will be more than 10 miles from their polling places and outside their home counties on election day are eligible for absentee voter ballots.

Applicants for primary ballots must designate their party affiliation. Otherwise, there is no way to tell whether they should receive ballots listing Democrats or Republican candidates.

March 7—First day for civilians outside the continental limits of the United States, such as wives of military men, to apply for absent voter ballots.

March 26—Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

April 6—First day for absent and disabled voters within the United States to apply for ballots.

May 1—Last day for "absent or disabled" civilians to apply. The deadline is 4 p. m.

May 2—Last day for civilians to return voted ballots to election boards to have them count. The deadline is noon of that day. Military personnel have until noon of election day, May 6.

May 3—Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.

Report Shows Influenza Incidence In Ohio Hit Peak the Week Of October 28

Deaths in which influenza was the primary or contributory cause totalled 267 in last fall's influenza epidemic throughout Ohio, the Ohio Department of Health has reported.

Influenza morbidity and mortality took its highest toll in the 60 and older age group, accounting for 156 deaths (12.8 per 100,000 population), the report shows. Deaths in the less than one-year-old age group amounted to 14 (7.2 per 100,000). Figures for other age groups contained in the report show the following:

Age 5 to 9, 10 deaths (1.3 per 100,000); 10-19, 12 deaths (0.66 per 100,000); 20-39, 24 deaths (0.98 per 100,000), and 40-69, 46 deaths (2.10 per 100,000).

First reports of such influenza cases were received September 2, and the number of cases numbered less than 100 for the next four weeks. By October 7 the number of cases reported weekly rose above the 200 mark, and increased sharply, reaching 3,300 the week of October 28. The weekly total of new cases decreased just as sharply, dropping to 500 the week of November 4 and to a little less than 200 the week of December 2.

The peak week of new cases—October 28, also had the highest week total of deaths in which influenza was a primary or contributory cause, the number for that week being 67.



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DOSAGE:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

ACHROSTATIN V combines ACHROMYCIN† V ... the new rapid-acting oral form of ACHROMYCIN† Tetracycline ... noted for its outstanding effectiveness against more than 50 different infections ... and NYSTATIN ... the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

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Mental Health Conference . . .

Report on AMA-Sponsored Chicago Meeting Is Made by Dr. Palmer. Chairman of OSMA Committee; Four of Major Points Are Discussed

DR. DWIGHT M. PALMER, Columbus, chairman of the Committee on Mental Hygiene, Ohio State Medical Association, officially represented the association at the Fourth Annual Conference of Mental Health Representatives of State Medical Associations in Chicago last November. The conference was sponsored by the American Medical Association. Here is a terse report by Dr. Palmer on the meeting:

"It was my privilege to represent the Ohio State Medical Association at the Fourth Annual Conference of Mental Health Representatives of State Medical Associations at Chicago in November, 1957. Delegates were present from almost all of the state medical associations and the conference proved to be an interesting and stimulating experience.

"There were four general topics on the agenda. The following statements are not the official findings from the conference but do represent what appeared to me to be the more important conclusions of the group.

"1. **The Role of the General Practitioner in Relation to the Specific Psychiatric Case:** The general practitioner is able to do a great deal in the management of emotional and mild mental illnesses without becoming involved in major psychiatric theories and terminology. Psychiatrists can be of assistance by establishing avenues of communication with the general practitioner at his level of training and practice.

"2. **Blue Cross-Blue Shield and Other Voluntary Health Insurance Plans for the Psychiatric Patient:** Psychiatry should be recognized as an integral part of medicine and no stigma should be attached to nervous and mental disorders. Psychiatrists should not be urged to falsify diagnoses and they should make available their specialized professional knowledge to those who are responsible for the successful operation of Blue Cross-Blue Shield and other types of voluntary insurance plans.

"3. **Relationship of the Psychiatrist in Private Practice to the General Hospital in His Community:** It is expected that an increasing number of psychiatric beds will be made available in general hospitals in the near future. There are many advantages to this arrangement. The general hospital provides a place for early and readily available treatment; the patient remains under the care of the same family physician and the same psychiatrist; consultants and laboratory services of high quality are available; there is continuity with the family, employer and various community agencies; and finally, the psychiatrist has a better opportunity to keep abreast with general medicine.

"4. **Psychiatric and Related Mental Health Problems in Industry:** This is a relatively new and growing area in the mental health field. Some of the topics considered were alcoholism, the hiring of the handicapped, the mental health of executives, the practice of industrial psychiatry in small industries, and retirement policies. No final solutions were formulated for these pressing problems but their importance was emphasized."

Magnetic Springs Center To Continue Under Reorganized Program

Final steps in a complete reorganization program of the Magnetic Springs Foundation were made recently. The program had been hampered by the untimely death of rehabilitation center's founder and director, the late Dr. Kenneth W. Keever.

Dr. Richard D. Burk, Columbus physician and professor in the Department of Rehabilitation, Ohio State University, has been named medical director on a part-time basis. Dr. Burk received his medical training at Creighton University in Omaha, Nebraska. He served in the U. S. Navy from 1943 to 1946. Stricken with polio in 1949, he spent a year at the Sister Kenny Foundation, Minneapolis, Minn. He joined the Ohio State University staff in 1952.

Dr. Lloyd Moore will continue on the staff as assistant medical director. Named as full-time administrator at the center is Daniel L. Calnan. President of the foundation, Charles M. Frank, reported that all functions of the hospital are working at their peak of efficiency.

"All persons directly or indirectly associated with the foundation, including members of the reorganized board of trustees, have signified the intense desire to carry on the work so ably started in these first years," Mr. Frank said. "The foundation expects to immediately undertake an expanded program of activity." The foundation is dedicated to rehabilitation work, particularly in the field of polio.

How Old is Too Old for Tranquilizers ?

The psychological needs of the elderly confront physicians with one of their most perplexing problems. Perhaps no other patient group suffers so much from emotional distress. Yet, precisely because of their age, geriatric patients often seem beyond the reach of tranquilizing treatment.

When tranquilization seems risky . . .

They are too much beset by complicating chronic ailments, too susceptible to serious side effects. Ataraxia is clearly indicated, yet the doctor cannot risk side reactions on liver, blood or nervous system.

Is there an answer to this dilemma?

We feel there is. In four recent papers investigators have reported good results with ATARAX in patients up to 90 years of age.* In one study, **improvement was "pronounced" in 76%, "good" in an additional 18.5%.*** ATARAX has been successfully used in such cases as senile anxiety, agitation, hyperemotivity and persecution complex.* On ATARAX, patients became ". . . quieter and more manageable. They slept better and demonstrated improved relations with other patients and hospital personnel. Even their personal hygiene improved, and they required less supervisory management."*

. . . ATARAX is safe

Yet even in the aged, ATARAX has given "no evidence of toxicity. . . . Complete liver function tests and blood studies were made on all patients after two months of therapy. . . . There were no significant abnormalities."* With still other elderly patients "tolerance to the drug was excellent, even in cases where the patients were given relatively high doses."* Similarly, no parkinsonian effects have been observed on ATARAX therapy.

Nor does ATARAX make your patients want to sleep all day. Instead, they can better take care of themselves, because ATARAX leaves them both calm and alert. In sum, ATARAX ". . . does not impair psychic function and has a minimum of side effects. . . . It appears that ATARAX is a safe drug. . . ."*

These, undoubtedly, are the results you want when emotional problems beset your geriatric patients. For the next four weeks, won't you prescribe tiny ATARAX tablets or pleasant-tasting ATARAX syrup – both so readily acceptable to the elderly.

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for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

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Licenses Granted . . .

Certificates To Practice in Ohio Are Issued to 66 Graduates of Medical Schools as a Result of the December Examinations of the Medical Board

RESULTS of the examinations conducted by the State Medical Board of Ohio on December 17-19, 1957, were considered by the Board at its meeting on January 28. On the basis of the examinations, 66 graduates of schools of medicine were authorized to receive certificates to practice medicine and surgery. In addition, 19 graduates of osteopathic schools were authorized to receive certificates to practice osteopathic medicine and surgery.

In the limited practice branches, certificates were awarded to 1 chiropodist, 6 mechanotherapists, 8 chiropractors, 5 masseurs and 2 cosmetic therapists.

Highest grade in the examinations in medicine and surgery was made by Robert J. Panaro, Youngstown, a graduate of the University of Ghent, Belgium. His average was 92.1.

Second high grade went to Carl J. Mader, Akron, a graduate of Dalhousie University, Canada, who scored 88.9. A close third with a grade of 88.8 was Hartmut T. Weber, New York City, a graduate of the University of Heidelberg, Germany.

Following are the names of those licensed to practice medicine and surgery. (Home address is given in parentheses if the home address is different from the place of residence at the time of examination.

Graduates of U. S. and Canadian Schools

Barrett H. Bolton, Akron, Northwestern University; Gust Boulis, Youngstown (Vandergrift, Penna.) Jefferson Medical College; Robert G. Carter, Kent (Alliance), University of Washington;

Herbert F. Cronin, Toledo, University of Pittsburgh; Joel K. Eakins, Cuyahoga Falls, University of Illinois; Burril B. Fine, Detroit, Mich. (Montreal, Canada), University of Montreal; John W. Foderick, Mogadore (Toronto, Canada), University of W. Ontario; Gerald Goldberg, Cleveland (Toronto, Canada), University of Toronto;

Charles A. Hattaway, Toledo, University of Michigan; Arthur W. Haines, Toledo (N. Madison), University of Michigan; Dale R. Hines, Cincinnati (Fairborn), Northwestern University; John G. Kramer, Toledo (Swanton), Northwestern University;

Carl J. Mader, Akron (Nova Scotia, Canada), Dalhousie University; Thomas W. Mahoney, Jr., Toledo, Georgetown University; Theodore F. Marsh, Cleveland, Loyola University; Juan H. Montier, Cleveland (Boston, Mass.), Howard University; Michael D. Orlando, Columbus (Youngstown), Northwestern University;

Paul Radetsky, Columbus (Denver, Colo.), University of Colorado; John W. Rechsteiner, Springfield (Akron), Ohio State University; Richard D. Ruffin, St. Louis, Mo. (Cairo, Ill.), Meharry; Samuel J. Sallomi, Akron, (Aurora, Ill.), Northwestern University;

Gilbert M. Schiff, Cincinnati, University of Cincinnati; James H. Steiner, Akron (Sterling), Hahnemann University; James R. Stull, Springfield, Jefferson Medical College;

Ramon W. Vera, Garden City, Mich. (Moca, Puerto Rico), Louisiana State University; Langdon T. Williams, Jr., Columbus, Jefferson Medical College; Wilbur L. Zike, Akron, McGill University.

Graduates of Foreign Schools

(Arranged alphabetically by country in which medical school of graduation is located.)

Austria: University of Vienna—Taylor A. Osten, Michigan, N. D.

Belgium: University of Ghent—Robert J. Panaro, Youngstown.

Brazil: University of Para—Aniceto P. Carneiro, Steubenville.

Chile: University of Chile — Benjamin C. Guttman, Houston, Texas.

Cuba: University of Havana—Juan A. Young, Buffalo (Havana, Cuba).

France: University of Montpellier — Joseph Yared, Cleveland (Euclid).

University of Strasburg—Gunther Ceelen, Columbus.

W. Germany: University of Bonn—George L. Lielbriedis, Bolivar, Tenn.

University of Erlangen—Maria A. Manacka-Huk, Willard, N. Y.

University of Freiburg—Gertrud B. Brecht, Cincinnati.

Germany: University of Heidelberg — Edmundas Lenkauskas, Cleveland; Hartmut T. Weber, New York City.

University of Munich—Alexander S. Lermer, Akron; Ivan O. Meyer, Akron; Kurt W. Michaelis, Richmond, Va.; Vladimir Shkilnyk, Cam-

bridge, Mass.; Luba C. Stefaniwsky, Irvington, New Jersey.

University of Peter Pazmany—Nicholas M. Juhasz, Asbury Park, N. J.

University of Wursburg—Joachim H. Wittoesch, Rochester, Minn.

England: Royal College of Physicians and Surgeons, London—Joseph H. Rayner, Lima.

Hungary: University of Budapest—George B. Zaboji, Middletown, Conn.

University of Debrecen—Albert Enrody, Toledo.

Italy: University of Bologna—Gaetano Roncagli, Cleveland; Anthony P. Russo, Toledo (Brooklyn, N. Y.)

University of Rome — Amore Longano, Chicago, Ill.; Agim Leka, New York City; Samuel F. Petraglia, Pittsburgh, Pa.

Japan: Keio Gijuku University—Chishu T. Uesu, Dayton (Honolulu, Hawaii).

Lebanon: French University of Beirut—Antoine M. Harouny, Cleveland.

Lithuania: University of Kaunas—Lilija Ignatonis, Cambridge; Stepas Sviderskas, Lincoln, Ill.

Mexico: National Autonoma University—Alfred Jasso, Akron.

Philippines: St. Thomas University—Flavio F. Talens, Buffalo, N. Y.

Rumania: University of Bucharest—Victor Brandus, New York City.

Russia: Second Medical School in Moscow—William Carroll, Richmond, Va.

Switzerland: University of Berne — Leslie Lorenson, Columbus.

University of Geneva—Philip Zeitler, New York City.

University of Lausanne—Irwin A. Silverstone, Newark, N. J.

Ukraine: Medical Institute of Kiev—Vladimir Boldowsky, Staten Island, N. Y.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

December 18, 1957—Herbert Joseph Leary, Cambridge, Syracuse College of Medicine; Edwin W. Smith, Cincinnati, Boston University; Robert S. Van Dervort, Elyria, University of Pittsburgh.

January 28, 1958—Robert Brown Ainslie, Cleveland, Univ. of Rochester; Theodor Bonstedt, Toledo; Univ. of Munich; Earl Brightman, Cleveland, Univ. of Toronto; Marvin J. Brown, Cleveland, Univ. of Zurich, Switzerland; Ernest Gordon Brookfield, Cleveland, Univ. of Michigan;

Hammond Pang Chen, Canton, Nat. Medical College of Shanghai; Fred George Conrad, Columbus, Univ. of Rochester; Thomas Mallon Daniel, Cleveland, Harvard Medical School; John Douglas Denison, Ashtabula, Univ. of St. Andrews, Scotland;

John Crawford Gillen, Wellston, Vanderbilt University; David R. Ginder, Youngstown, Harvard Medical School; Ervin Alexander Gombos, Univ. of Zagreb, Yugoslavia; Edward A. John, Worthington, Col. of Med. Evangelists; Wenner Dudley Johnson, Columbus, Univ. of Illinois;

Layton Maurice Kest, Cleveland, Northwestern University; Walter Reid Kohlheim, Temple; Alfons Landwehr, Univ. of Goettingen; Russell E. Leach, Cambridge, Tufts Medical School; Benjamin Harrison Libien, Toledo, Univ. of Louisville; Hwei-Ya Chang Loh, Cleveland, Nat. Hsiang Ya Medical College, China; J. Wei-Ping Loh, Cleveland, National Medical College of Shanghai; Athey Ragan, Lutz, Med. College of Virginia;

Hilbert Mark, Toledo, Univ. of Minnesota; Julius Nemeth, Massillon, Univ. of Budapest; James F. Nichols, Rocky River, Tufts Medical School; Essex Crystol Noel, III, Cincinnati, Meharry Medical College; Louis W. Nowack, Bowling Green, Northwestern University; Thomas G. Olsen, Columbus, Univ. of Wisconsin;

Jaroslav George Panchuk, Friedrich Alexander Univ., Erlangen, Germany; John L. Porter, Cleveland, Loyola University; Lorand C. A. Reich, Univ. of Budapest; Joseph E. Russell, Cincinnati, St. Louis University;

Mackenzie Smith, Cincinnati, Univ. of Washington; Frederick Abbott Smith, Berea, Univ. of Minnesota; Robert J. Smith, Meharry Medical College; Robert Douglas Wayman, Columbus, State Univ. of New York.

Three Ohio physicians are on the program of the Fifth Bahamas Medical Conference to be held in Nassau, Bahamas, April 1-12. They are Dr. Ralph I. Fried, Cleveland; Dr. Irvine H. Page, Cleveland; and Dr. Leonard Gottesman, Cincinnati. Details may be obtained by writing (10 cents air mail) to Dr. B. L. Frank, Bahamas Medical Conference, Dolphin Hotel, P. O. Box 1718, Nassau, Bahamas.

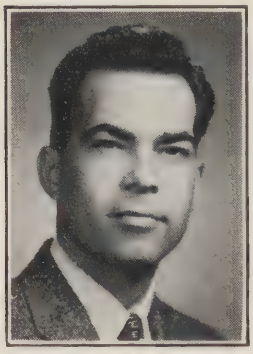
New Executive Secretaries . . .

Summit County Medical Society and Cleveland Academy Appointees Announced; Ohio Academy of General Practice Has New Executive

EXECUTIVE Secretaries of three Ohio medical organizations have been named recently. The first executive secretary of the Summit County Medical Society has been appointed and new executive secretaries for the Academy of Medicine of Cleveland, and the Ohio Academy of General Practice have been announced.

Summit County Society

The Summit County Medical Society has taken on its first full-time executive secretary, Sidney H. Mountcastle, who will maintain offices in Akron.



Sidney H. Mountcastle

For the last six years, Mr. Mountcastle has been director of the "American Cancer Society's Canton-Stark County Unit. Under his direction the unit developed as a kind of laboratory for community-wide cancer control pilot programs which have been copied widely. Four of the nation's approximately 600 approved cancer diagnostic clinics were organized and subsidized by Stark County Doctors and his office. The office also established the first county-wide registry of cancer patients, a service it continues to maintain. In 1956 his office received the Ohio Division, American Cancer Society, citation for helping staffs of Stark Hospitals establish programs of cancer re-education for the medical profession in the area.

Mr. Mountcastle is a native of Lakewood and a veteran of three years service in the Marine Corps. At Kent State University he studied journalism and public relations while taking extra work in adult education at Mount Union College at Alliance.

In his new work he will be assigned to organizing and implementing community service efforts of the Society. Internally, his main responsibility will be to improve and add to practical services to Society members.

The new executive secretary is married and the father of three children.

Cleveland Academy of Medicine

The Cleveland Academy of Medicine has named as its new executive secretary Robert A. Lang who had been assistant professor in the Speech Department of Western Reserve University until he assumed his new duties early in February. Mr. Lang succeeds M. John Hanni, Jr., after the latter resigned to accept a similar post with the Dade County (Florida) Medical Society.



Robert A. Lang

Mr. Lang has an outstanding record of advancement in the education field and an enviable record of service in the Air Force during World War II. A native of Cleveland he obtained his bachelor degree from Western Reserve in 1941 and that same year went into the Air Force. Rising from the rank of private to captain he served considerable time as photo intelligence officer in Europe.

After the war he became a teaching fellow at Western Reserve and earned a Master's degree in 1947. In 1950 he was awarded the Ph. D. degree from Northwestern University. In addition to his assistant professorship at the university he has considerable experience in radio and television work. Affiliations include memberships in the City Club, the American Association of University Professors, Speech Association of America and the Broadcasting Council of WRU.

Elected a councilman for the City of South Euclid in 1957, he is chairman of the legislative committee; also chairman of the McBride Lecture Foundation since 1951. He has organized and trained speakers bureaus for various industrial organizations in the Cleveland area.

Mr. Lang is married and the father of two daughters.

Ohio Academy of GP

The Board of Directors of the Ohio Academy of General Practice named as its new lay executive

secretary David J. Byrnes who assumed the position January 1.



David J. Byrnes

Mr. Byrnes was born in Columbus and took his college preparatory work in the Columbus schools. He entered Cornell and received a B. S. degree in 1930. He was then admitted to Medical School (Cornell) and continued there until he developed bulbar poliomyelitis in his senior year. Confined to a respirator supposedly for life, he was granted an M. D. degree from Cornell. His condition improved and he accepted a scholarship to Columbia where he completed work leading to a degree in law (LL. B.) and a degree in business administration (B. S.) both in 1936.

His work has been in the field of sales promotion and publicity management, hospital consultation, construction equipment and the teaching of personnel in techniques and procedures. Respective associations were with DuPont, the Wright Aeronautical Corporation, the Chrysler Corporation, Joseph Lucas, Ltd., of Birmingham, England. During World War II he did special intelligence work for the U. S. Government.

Mr. Byrnes is a member of the Executive Clubs of America, the Masonic Lodge, the Athletic Club, the Advertising Clubs of America, the American Sales Managers Association and the Episcopal Church.

Heart Association Makes Booklets Available

Three new booklets prepared especially for adult heart patients placed on sodium-restricted diets by their physicians have been published by the American Heart Association, Dr. Maurice A. Schnitker, president of the Ohio State Heart Association, announced.

The booklets are available from the chapters of the OSHA and also may be obtained by writing the OSHA, 131 E. State St., Columbus 15. The titles are: "Your Mild Sodium-Restricted Diet," "Your 1000 Milligram Sodium Diet," and "Your 500 Milligram Sodium Diet."

Two contributions, one of $107,000 from the Timken Roller Bearing Company Charitable Trust and a second of $100,000 from the Timken Foundation, have been made to the Bucyrus Community Hospital Building Fund.

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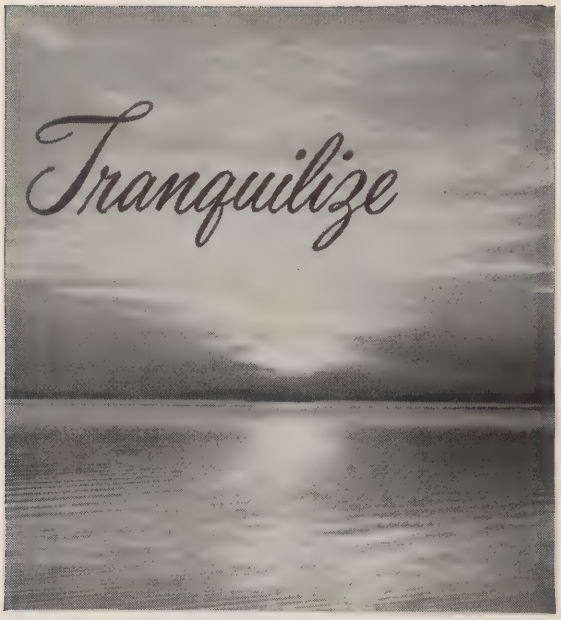


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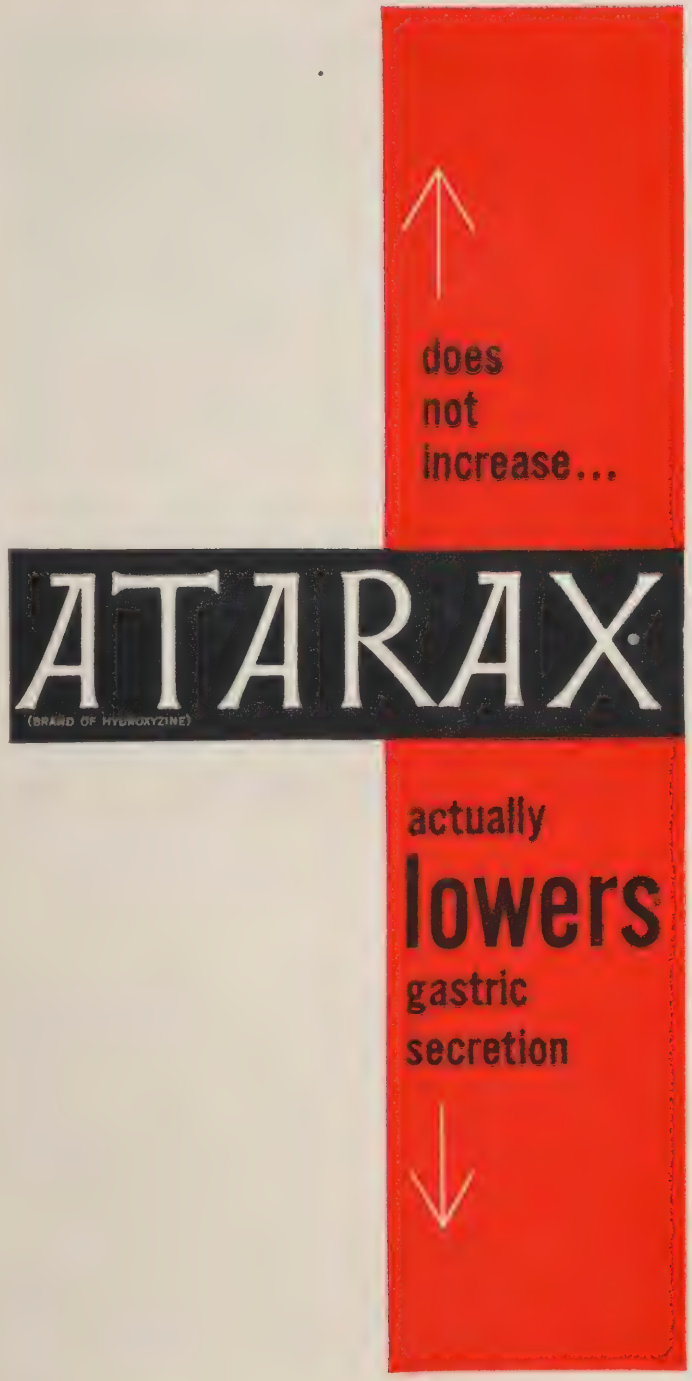
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Reference literature and samples available from sales representative or write direct:

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supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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In Memoriam . . .

Theodore K. Bange, M. D., Cincinnati; Miami Medical College, Cincinnati, 1905; aged 75; died January 5; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. A native of Cincinnati, Dr. Bange served all of his professional career of more than a half century there. He was a member of the Elks and Masonic Lodges, a former deputy coroner of Hamilton County and captain in the Army Reserves. Survivors include a daughter and a brother.

Joseph Walter Barker, M. D., Harbor Hills and Newark; Baltimore Medical College, 1898; aged 84; died January 19; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Barker moved to Newark in 1902 and practiced there until his retirement in 1954. For 27 years he served on the board of YMCA and was its president for many years. He was a member of the Presbyterian Church and several Masonic bodies. His widow survives.

John P. Beneke, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 80; died January 14; member of the Ohio State Medical Association and the American Medical Association through 1956. A practicing physician in Cincinnati for more than a half century, he had received the 50-Year Award of the OSMA. A member of the Evangelical and Reformed Church, he is survived by a sister.

Asher C. Biddle, M. D., Mansfield; College of Physicians and Surgeons of Baltimore, 1904; aged 84; died January 13; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Biddle practiced medicine for more than a half century. He moved to Mansfield in 1928 after previously practicing in Columbus and in Lewistown, Mont. Surviving are his widow, two daughters, a sister and two brothers, Dr. David Biddle, Athens, and Dr. Benjamin Biddle, Lancaster.

Edward Cook, M. D., Hamilton; Medical College of Ohio, Cincinnati, 1902; aged 91; died January 19; former member of the Ohio State Medical Association. Dr. Cook served all of his professional career in Hamilton and was Butler County coroner for 30 years. He also served a term as city councilman. His activities included memberships in the Order of Eagles, the Police Mutual Aid Society and the Catholic Church. Surviving are his widow, two sons, a daughter and a sister.

Andre Crotti, M. D., Columbus; Faculty of Medicine, University of Lausanne, Switzerland, 1900; aged 84; died January 31; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association and the International College of Surgeons, and Fellow of the American College of Surgeons. Dr. Crotti was an internationally known teacher, author, surgeon and researcher. He was the first president of the United States Chapter, International College of Surgeons, and second president of the International organization. The ICS dedicated the May-June, 1949 issue of its journal to him. He helped found what is now the Columbus Cancer Clinic and took an active part in its work. During World War I Dr. Crotti served with the Medical Corps of the U. S. Army and received decorations from Poland, France and Italy. He was a member of the Catholic Church. Survivors include his widow, and his son-in-law and daughter, Dr. and Mrs. Maurice G. Buckles.

Nathan P. Frolkis, M. D., Augusta, Ga.; Western Reserve University School of Medicine, 1936; aged 46; died January 14; former member of the Ohio State Medical Association; member of the American Medical Association and the American Academy of General Practice. A former practicing physician in Akron, Dr. Frolkis gave up private practice for health reasons and became associated with the Veterans Administration. He was on the staff of the VA Hospital in Augusta, Georgia. Surviving are his widow, two daughters, a son, his mother and a brother.

Alfred George Goll, M. D., Stryker; Northwestern University Medical School, 1899; aged 85; died January 26; former member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. A native of Williams County, Dr. Goll practiced there all of his professional career. Active in community affairs, he was for 40 years a member of the local school board; he also was a 32nd Degree Mason and a member of the Lutheran Church. Surviving are his widow, a daughter, a sister and two brothers. One brother is Dr. Charles Goll, also a practicing physician in Stryker.

Sidney Littman, M. D., Santa Barbara, Calif.; Western Reserve University School of Medicine, 1918; aged 67; died January 19; former member of the Ohio State Medical Association. Dr. Littman practiced medicine in Cleveland for 35 years.



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He retired in 1955 and moved first to Florida and later to California. His widow and a daughter survive.

Clark E. Hetherington, M. D., Cincinnati; Chicago Homeopathic Medical College, 1901; aged 83; died January 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Hetherington was a native of Piqua and practiced there from 1901 until his retirement in 1954. Surviving are his widow, three brothers and two sisters.

William Briscoe Robinson, M. D., Los Angeles, Calif.; Medical College of Ohio, Cincinnati, 1896; aged 90; died January 22. A practicing physician in Mt. Gilead for 50 years, Dr. Robinson had been residing in California for the past five years. Survivors include his widow, three daughters and two sons, one of whom is Dr. Gerard B. Robinson, of Mt. Gilead.

Albert H. Sealy, M. D., Columbus; Ohio State University College of Medicine 1912; aged 75; died January 15; member of the Ohio State Medical Association and the American Medical Association. Dr. Sealy had been a practicing physician in Columbus for 45 years. Affiliations included membership in the Masonic Lodge. He is survived by a son. Also surviving are brothers and sisters in England.

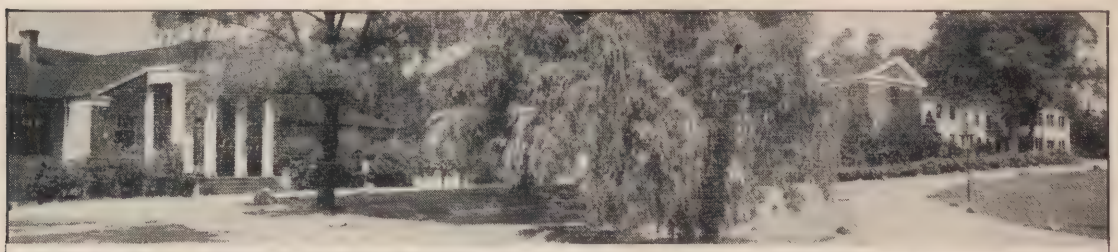
Robert Benjamin Smith, M. D., Akron; Ohio State University College of Medicine, 1940; aged 42; died February 2; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Smith was a life resident of Akron. He was a member of the Kiwanis Club, the Torch Club, University Club, Akron City Club and the Congregational Church. Surviving are his widow, two sons, a daughter, his father and a brother.

August C. L. Werner, M. D., Cincinnati; University of Louisville School of Medicine, 1908; aged 77; died January 13; member of the Ohio State Medical Association and the American Medical Association. A native of Cincinnati, Dr. Werner practiced there many years and for 41 years was head of the medical department of the Lodge & Shipley Company. From 1913 to 1917 he was superintendent of the Dayton State Hospital. Surviving are his widow, a son, two daughters and a sister.

Jacob A. Yoder, M. D., Mansfield; University of Wooster Medical Department, Cleveland, 1898; aged 89; died January 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Yoder began his practice in Lucas and moved to Mansfield in 1904. He had been honored with the 50-Year Award of the OSMA and with an award for 50 years service on the staff of the Mansfield General Hospital. A 32nd Degree Mason and a member of the Methodist Church, he left four grandchildren and nine great-grandchildren.

The Illinois State Medical Society is sponsoring a trip to the Hawaiian Islands in connection with the Annual Session of the American Medical Association in San Francisco in June. The party will leave by air the night of June 26 from San Francisco. Physicians from other states and members of their families are invited to join the group.

Natural increases in the population of the United States in 1957 added about 2,680,000 persons and migration added another 330,000, making the total population (including the Armed Forces overseas) 172,830,000 at the end of the year. Since the 1950 census, 21,700,000 have been added to the population, or an increase of 1.7 per cent annually.—Metropolitan Life.



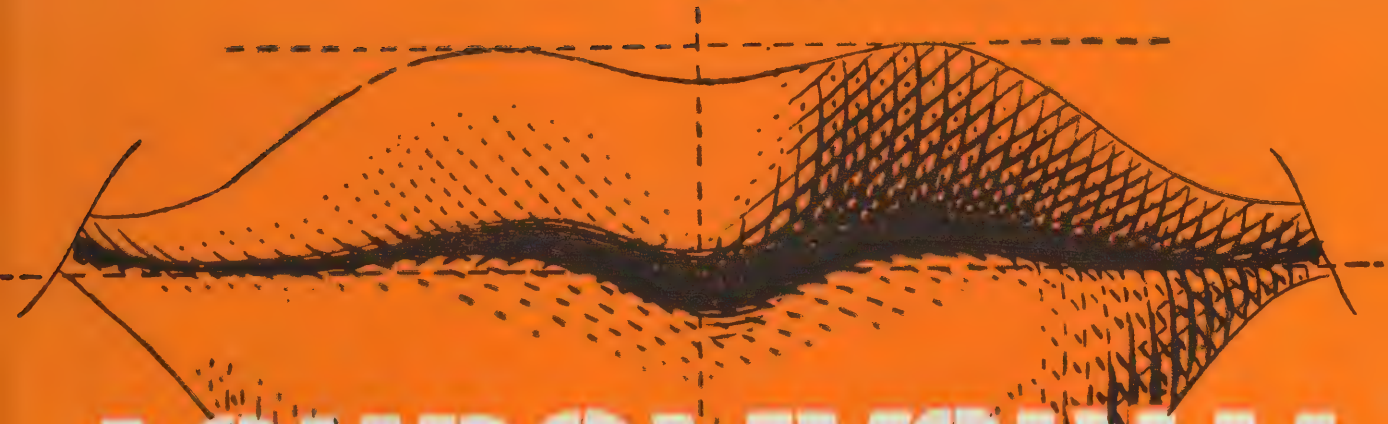
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Acetylsalicylic acid	325 mg.
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Packaging: Sigmagen Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

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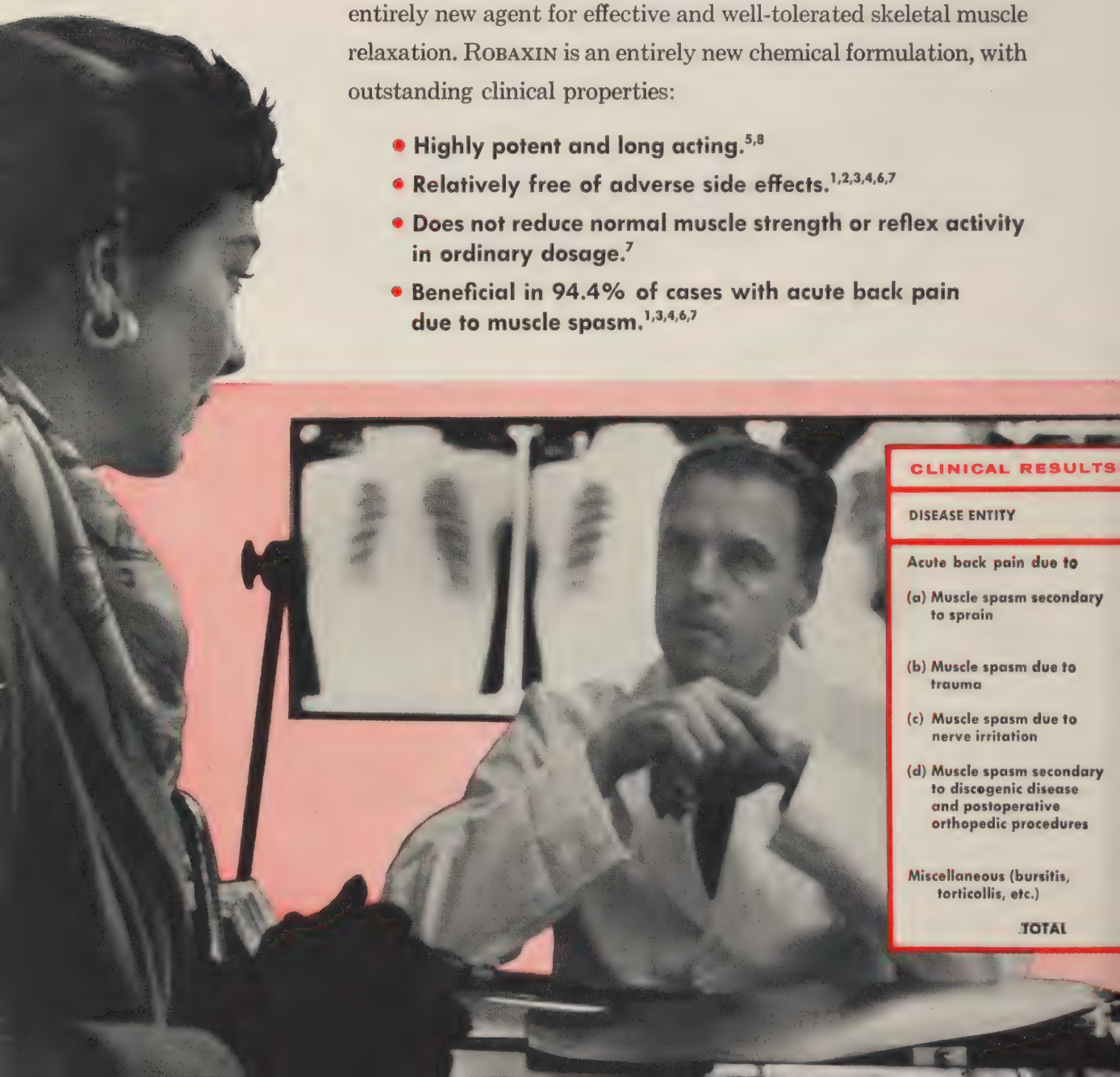
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- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



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Acute back pain due to
(a) Muscle spasm secondary to sprain
(b) Muscle spasm due to trauma
(c) Muscle spasm due to nerve irritation
(d) Muscle spasm secondary to discogenic disease and postoperative orthopedic procedures
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ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

WITH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

NO. OF CASES	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
18	2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
13	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
5	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
30	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
6	3-60 days	4-8 Gm.	6	0	0	0	None, 6
72			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

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3. Carpenter, Theodore. Arch. Dermat. 76:172, June, 1957.

Activities of County Societies . . .

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(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

Members of the Clermont County Medical Society met on February 19 at the Millcroft Inn, Milford, with Dr. George J. Watkins as host. Dr. William E. Hillard, Cincinnati, discussed the subject, "Tranquilizers."

HAMILTON

The Academy of Medicine of Cincinnati in cooperation with the Southwestern Ohio Society of General Physicians sponsored a program January 21 on the subject, "The Rational Handling of Diabetes." Guest speaker was Dr. Rachmiel Levine, chairman of the Department of Medicine and director of the Department of Metabolic and Endocrine Research, Michael Reese Hospital, Chicago.

The February program of the Academy of Medicine of Cincinnati included the following features:

February 4—"Work in Congress and the Activities of Our Legal Watchdogs," C. Joseph Stetler, director of the Law Department, AMA.

February 18—"The Endocrinology of Normal and Abnormal Sexual Behavior," Dr. Robert Greenblatt, professor of endocrinology, Medical College of Georgia.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Speaker for the January 20 meeting of the Clark County Medical Society was Dr. Warren E. Wheeler, professor of pediatrics at Ohio State University and medical director of the Columbus Children's Hospital. His talk entitled "Beware—the Laboratory," was one in which he emphasized the necessity for a knowledge of laboratory technique and practice in order for the physician to interpret clinically the results.

Dr. George D. Whitacre was honored for his half century of devotion to responsibility as a practicing physician. Because Dr. Whitacre was unable to be present at the meeting, Dr. R. Dean Dooley, Dayton, Second District Councilor, Dr. E. W. Schilke and Dr. J. Harold Shanklin made the presentation at his home.

Dr. Whitacre established his practice in Springfield in 1907. Commenting in the society bulletin, President Schilke said of Dr. Whitacre, "He can look back with pride on his long years of useful and distinguished work. Elizabeth Barrett Browning states it best in the following lines: (the lines are from the "Reward of Service," ending "Thou shalt be served thyself by every sense Of Service which thou renderest."

Dr. Montanus reported on the work of the Committee that was formed to study the advisability of a uniform procurement of interns at both Springfield Hospitals. The following are the Committee's recommendations: Such a program must be impartial. At the start the assignment of interns would not be by the Medical Society or the Committee. Procurement must be separated from the hospitals. The Society shall control and finance entertainment for prospects. The Chairman of the Committee should not be the head of the Hospital Committee but the Hospital Committee heads shall be members of the Society's Committee.

A motion was passed favoring the Society joining the Clark County Blood Assurance Program. This motion was then brought to the floor for vote and passed by the Society.

Bulletin note: A question to be asked the guest speaker at each meeting—"What do you think the principal or primary function of a County Medical Society should be?" Dr. Wheeler's answer was—"To help members in getting to know each other."

(The foregoing excerpts are from the Society Bulletin with Dr. Harold Fishbain and Dr. H. M. Tardif, editor and co-editor.)

DARKE

An interesting discussion on "African Medicine" was presented by Dr. A. E. Thuma, New Madison, with the aid of color slides, at the January 21 dinner meeting of the Darke County Medical Society. The meeting was held in the Treaty City White Shrine Temple in Greenville.

The Darke County Medical Society held its regular monthly dinner meeting on February 18 at the Treaty City White Shrine Temple in Greenville. The subject "Office Proctology" was discussed.

GREENE

Dr. B. F. Lee, Xenia, has been named President of the Greene County Medical Society. Dr. Paul Vernier, Fairborn, has been named vice-president, and Dr. Carl Hyde, Yellow Springs, secretary-treasurer.

MIAMI

Miami County Medical Society met on February 7 at the Dettmer Hospital, Troy. Speaker was Dr. Edmund Saunders, of the Radiology Depart-

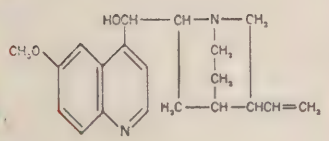
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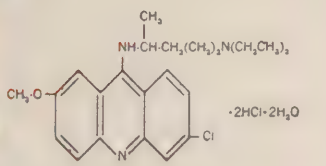
". . . Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

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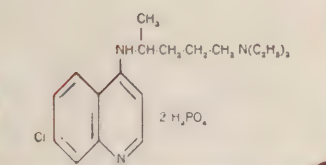
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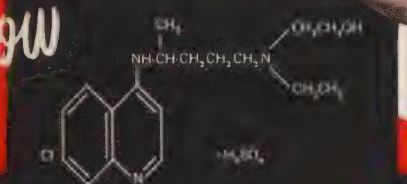
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REFERENCES:

1. Schertel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
2. Editorial: *Bull. A. Mil. Dermatologists*, The Shock Section 5:25, Nov., 1956.
3. Corabœuf, Theodore: Arch. Derm. 73:572, June, 1956.

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ment, Dettmer Hospital, who discussed the subject, "What Can You Expect from X-Ray Therapy?" The afternoon program was followed by dinner.

MONTGOMERY

Nearly 400 Montgomery County Medical Society members, their wives and guests witnessed the installation of 1958 officers at the annual inaugural meeting on January 10 at the Biltmore Hotel.

Installed as the 109th president of the Society was Dr. A. V. Black, of Centerville. Dr. R. Dean Dooley, retiring president, presided at the installation. Other officers serving for the first time in 1958 are: Dr. A. J. Carlson, president-elect; Dr. C. G. Livingood, vice-president; Dr. W. D. Welton, secretary; Dr. G. L. Parkin, treasurer; and Dr. L. E. Baker, trustee (3-Year term).

Officers previously installed but who will remain as Council members in 1958 are: Dr. Dooley, past-president; Dr. Richard C. Miller and Dr. Mason S. Jones, trustees; and Dr. F. L. Shively, Jr., chairman of the Past-Presidents' Committee.

The National Cash Register Company was host to members of the Montgomery County Medical Society for dinner and the meeting on February 7 in the Horseshoe Dining Room at NCR. Speaker for the occasion was Everett C. Yowell, Ph. D., whose topic was, "Electronics—Man's Next Slave."

The Dayton Obstetrical and Gynecological Society met on February 19 for a social hour, dinner and program at the Van Cleve Hotel, Dayton. Speaker was Dr. Warren E. Wheeler, professor of pediatrics at the Children's Hospital, Columbus. His topic was "The Obstetrician Looks at Blood Group Incompatibilities." Dr. Mason S. Jones acted as moderator for the program.

PREBLE

At a recent meeting of the Preble County Medical Society, Dr. Carle W. Beane, Eaton, was honored with the 50-Year Award of the Ohio State Medical Association. He was commended for his many years of devoted service in the medical profession and for his additional service to the community as Preble County health commissioner for 18 years and combined Preble-Darke County commissioner for several years.

Dr. R. Dean Dooley, Dayton, Councilor of the Second District, made the presentation.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Academy of Medicine of Toledo and Lucas County listed the following features on its program for February

February 6—Toledo Medical Library Association Annual Meeting, social hour and dinner followed by program.

February 13 and 14—Postgraduate Lecture Series: This program was presented by the Medical Advancement Trust of Maumee Valley Hospital and the Northwestern Ohio Heart Association. Lecturer was Dr. E. M. Papper, director of the anesthesiology service at Presbyterian Hospital, New York. His theme was "Physio-Pathology of the Cardio-Respiratory Systems."

February 21—Medical Section; "Medical Aspects of Hypoglycemia," Dr. Penn G. Skillern, III, Cleveland Clinic.

February 28—Surgical Section; "The Initial Management of the Burned Patient," Dr. J. C. Kelleher and Dr. J. G. Sullivan.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The January program of the Academy of Medicine of Cleveland included the following features:

January 17, a program on "Bronchial Asthma," presented by the Cleveland Allergy Society. The following subjects were discussed by speakers as indicated:

"The Allergic Individual and Asthma," Dr. William P. Garver;

"The Immunology of Asthma," Dr. Harold J. Friedman;

"Drugs Used in the Treatment of Asthma," Dr. Iredell M. Hinnant.

There followed a panel discussion with Dr. Myron A. Weitz as moderator, and a panel consisting of the foregoing speakers and Dr. Bram Rose. After dinner, Dr. Rose, associate professor of medicine, McGill University, presented the subject, "Recent Advances in the Mechanism of Allergic Reactions."

January 20, the Experimental Medicine Section of the Academy and the Cleveland Section of the Society for Experimental Biology and Medicine met for a joint program.

January 29, the Institute for Interprofessional Planning for Disaster Relief was held at the Hotel Carter. Participating in this program were the following: Colonel Joseph R. Shaeffer, Lieutenant Colonel Joseph D. Goldstein, Colonel Albert J. Glass, all of the Medical Corps, U. S. Army; Dr. Curtis H. Lohr, superintendent and director of the St. Louis County Hospital, Missouri; and Major Harriet H. Werley, Nursing Corps, U. S. Army

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

The following report of the January 9 meeting appeared in the *Youngstown Vindicator* and was forwarded by Dr. Clyde K. Walter, correspondent:

Dr. Stephen W. Ondash, retiring president of the Mahoning County Medical Society, was praised for his work and presented a plaque by associates at the annual dinner meeting (January 9) at the Youngstown Country Club.

Dr. Andrew A. Detesco, new president, was installed and pledged to carry on the society's program. The Dr. A. Earl Brant award, a hand-turned gavel made by the surgeon, was presented to Dr. Detesco by Dr. Ondash.

Dr. Chauncey Stewart and Dr. S. W. Goldcamp, who have practiced medicine here for 50 years, were given their 50-year awards, with Dr. Richard Goldcamp receiving the pin for his father. Dr. C. A. Gustafson, councilor of the Sixth District of the Ohio Medical Association, made the awards.

Dr. Ondash reviewed the year's work, pointing to a strengthening of the public relations program under the direction of Dr. L. S. Shensa and establishment of a health commissioner for Youngstown who must be a physician. The latter work was led by Dr. John J. McDonough.

Dr. William Neidus was installed as president-elect: Dr. A. K. Phillips, secretary, and Dr. Fred Schlecht, treasurer. The officers and delegates, Dr. H. P. McGregor, Dr. Ashar Randall and Dr. Paul Mahar, and alternate delegates, Dr. Craig Wales, Dr. C. W. Stertzbach and Dr. McDonough, make up the council. Dr. M. S. Rosenblum will edit the organization's Bulletin. Dr. Sidney Berkowitz,, rabbi of Rodef Sholom Temple, offered the invocation. More than 200 attended, including the wives of members.

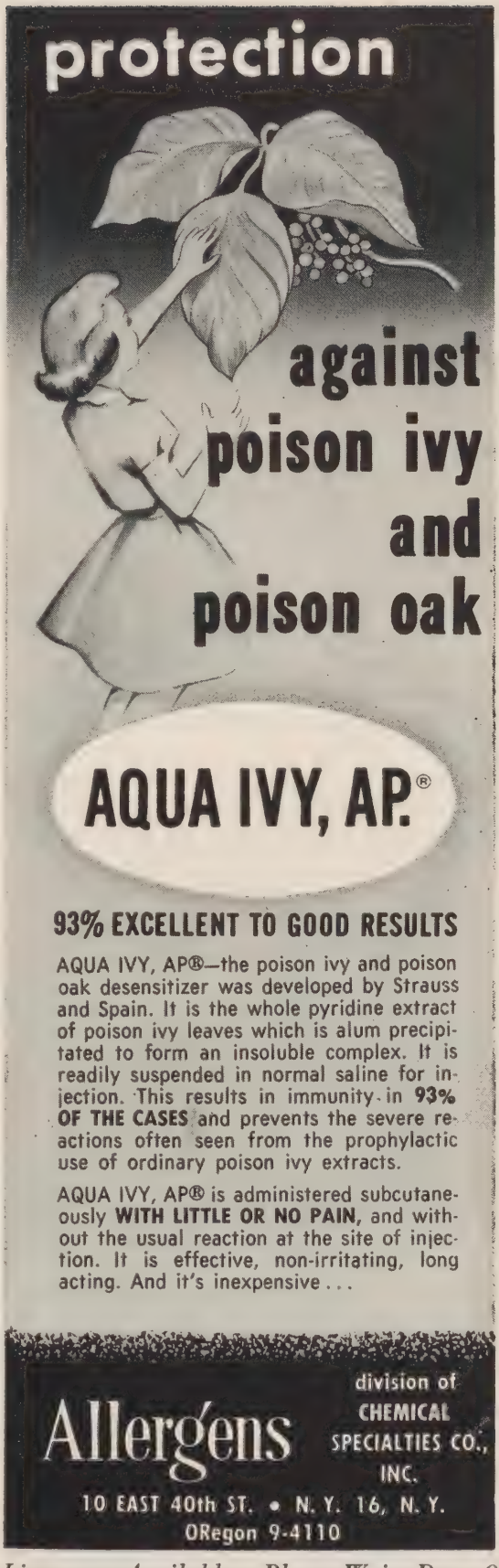
Adrian M. Slifka, television-radio editor of *The Vindicator,* spoke on "TV Interviews and Previews."

STARK

The Stark County Medical Society had as guest speaker on February 13 Dr. Scott N. Swisher, hematologist at the Strong Memorial Hospital, University of Rochester School of Medicine. His subject was "The Use and Abuse of Blood Transfusions." The evening meeting was held in the Belden Hotel, Canton.

SUMMIT

"Health Insurance" was the subject of discussion at the February 4 meeting of the Summit County Medical Society. The speaker was Dr.



Literature Available - Please Write Dept. 0

William J. McNamara, medical director, Bureau of Industrial Health, the Equitable Life Assurance Society of the United States. Dinner was served at the Akron City Club with the meeting following in the Akron General Hospital Auditorium.

TRUMBULL

With the January issue the Trumbull County Medical Society launched its new Bulletin. In it the Society secretary, Dr. Charles M. Stone, announced: "We hope that, from this humble beginning and with your help and cooperation, we may be able to produce a publication which will serve both to inform us and to guide us. Constructive criticism will be cheerfully accepted at any time."

The new president, Dr. Aubrey Sparks, outlined his program goals for 1958 with the following brief summary of the salient points:

1. Continue past effective programs and enlarge upon some, including an active speakers bureau.

2. Encourage continuation of private enterprise in medical practice, specifically regarding maintenance of immunizations in the physicians office and resistance to further attempts at socialization of medicine.

3. Maintain important committee functions by experienced members of each committee, probably making appointments for two and three years at a time.

4. To initiate and publish a bulletin for this society.

5. Revision of the constitution which was last revised in 1932.

6. Consideration of hiring an executive secretary for handling the increasing amount of administrative work in the society.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

Following is a report of the January 16 meeting of the Belmont County Medical Society as excerpted from the *Martins Ferry News:*

A United Mine Workers local union president told the Belmont County Medical Society Thursday that the miners "will fight to the end" for the "right to a choice of hospitals and doctors."

The speaker was Russel Whitlatch of Dilles Bottom, president of Local 3, Powhatan Mining Co., which has a membership of more than 900 members.

Whitlatch, who represents one of the 10 local unions protesting the cutting off of hospitals and doctors from participation in the United Mine Workers Welfare and Retirement Fund, and Lester Zimmerman, Cadiz, president of UMWA Local 283, had been invited to address the doctors. Zimmerman did not appear. (There followed an extensive report of Mr. Whitlatch's talk.)

Dr. David Dannenberg, Society president, said that Whitlatch's talk was enlightening and that it was the first time the medical profession had an opportunity to get a direct statement on the thinking of the rank and file miners.

Dr. Charles Hudson, Cleveland, a Past-President of the Ohio State Medical Association, advised a "cautious" approach to the "third party" (in medicine) problem. Dr. Hudson proposed a continuation of arbitration between the doctors and the people who control the UMWA fund.

Other speakers included Dr. Robert Martin, Zanesville, State President, and Dr. Robert Hopkins, Coshocton, District Councilor. A recommendation that the Belmont County Medical Society incorporate was approved.

The Belmont County Medical Society met on February 20 at the Bellaire City Hospital for a program, business meeting and dinner. The Upjohn Grand Rounds film "Recent Advances in Treatment of Liver Disease," was the feature of the scientific program.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

FAIRFIELD

George H. Saville, Director of Public Relations, Ohio State Medical Association, spoke on "You and Your Public" at a meeting of the Fairfield County Medical Society, Feb. 11, at Lancaster. He discussed the role of the AMA, OSMA, the county medical society and the practicing physician in maintaining public good will toward the medical profession.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society met at General Hospital in Portsmouth on February 10. The Upjohn film, "Three Questions on Coronary Artery Disease," was shown as the scientific program.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Annual Meeting of the Columbus Academy of Medicine was held on January 20 at the Grandview Inn, Columbus. Following dinner and the installation of officers, the main part of the

program featured a symposium on air and space travel presented by authorities in this field.

The topic was "The Physician's Role in Air and Space Travel—Present and Future." Speakers included Fred A. Hitchcock, Ph. D., professor of physiology, Ohio State University; Captain Sidney Leverett, U. S. Air Force; and Earl T. Carter, M. D., Ph. D., assistant professor of preventive medicine and physiology, Ohio State.

The next quarterly program of the Columbus Academy will be held in the Neil House, Columbus, Wednesday, April 9. This will be a joint meeting with the Columbus Bar Association. The general format of the program will feature a panel discussion, social hour and dinner to be followed by a speaker.

ROSS

The January meeting of the Ross County Medical Society was held at the Gold Key on the 9th. Thirty-two members and guests were present. Dr. Lewis W. Coppel, presided.

A number of letters from organizations were read thanking the Society for its activity and help which was given the various groups. Council meeting was announced to be held at Dr. MacCarter's residence. Committees for the coming year were announced. The Legislative Committee gave a report of two important bills; the Forand and the Jenkins-Keough Bills. An urgent plea was made by the Legislative Committee that individual letters go to Representatives rather than an organization endorsement.

Dr. Manchester then introduced the speaker for the evening who was Dr. Thomas A. Pomeroy of the X-Ray Department, Ohio State Medical Center. He discussed malignancies, the chemotherapy treatment and some of the newer concepts of the etiology of malignancies with emphasis on the theory that there is host resistance.—William M. Garrett, M. D., secretary-treasurer.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The Lorain County Medical Society held its January 14th meeting at the Oberlin Inn, Dr. B. V. Myers, newly elected president, presiding. In addition to the usual business, a Historical Committee was appointed. Each man is an honorary member, with the following active members: Dr. L. H. Trufant, Chairman; Dr. Valloyd Adair, Dr. George Nicholas, Dr. Birt Garver.

The major concern was discussion of H. R. 9, H. R. 10 and H. R. 9467. Dr. Paul Kopsch presented a concise and able analysis of these measures. Letters were sent by the members from

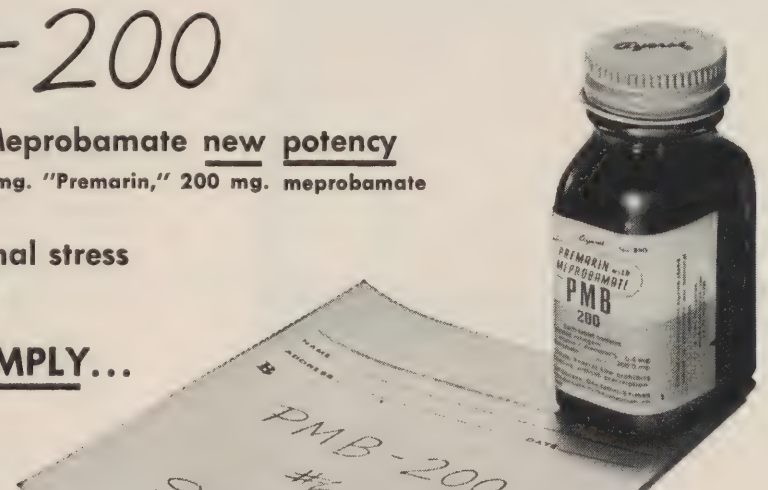
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this meeting to our Senators and Representatives urging their support of the H. R. 9 and H. R. 10, and their condemnation of H. R. 9467.—L. C. Meredith, M. D., Secretary-Treasurer.

WAYNE

"Forty to sixty per cent of your work overlaps," a Duke University expert told a gathering of 106 Wayne County physicians and ministers (January 15) in the Smithville Inn, reported the *Wooster Record*.

Dr. Russell L. Dicks, professor of pastoral care at the North Carolina school, addressed a combined dinner meeting of the Wayne County Medical Society and the Wayne County Ministerial Association.

The address concerned six areas in which the speaker said the two groups must be mutually alert: The dying person, the patient facing surgery, the convalescent, the alcoholic, couples with marital difficulties and senior citizens.

New manager of the Veterans Administration Hospital at Chillicothe is Dr. Sam Beanstock, former director of professional services at the VA Hospital in Lebanon, Pa. He succeeds Dr. Harry H. Botts who recently retired. Dr. Beanstock has previously served on the staff at the Chillicothe hospital.

American Academy of General Practice To Meet in Dallas, March 24-27

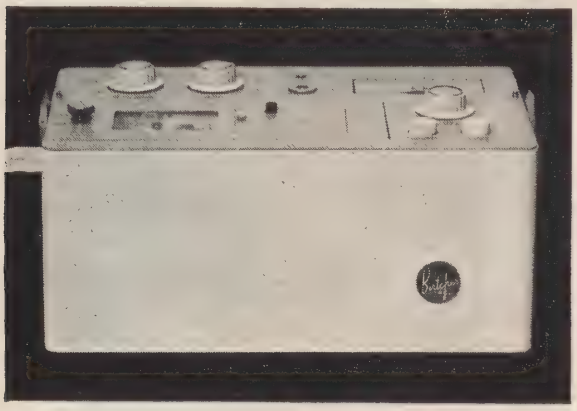
What are the emotional and physical problems of today's teen-ager? Can hypnosis cure headaches? What causes dizziness? These and countless other current questions will be answered at the American Academy of General Practice Tenth Annual Scientific Assembly, March 24-27 in Dallas' Memorial Auditorium.

The scientific program will feature 35 prominent physician-authorities. Ninety scientific and three hundred technical exhibits will be prepared for the 7,000 doctors and guests expected to attend. The Academy is presenting its scientific assembly in combination with the Dallas Southern Clinical Society.

The Congress of Delegates, policy-making body of the Academy, will convene March 22 at Dallas' Statler Hilton, the Academy headquarters hotel.

Details may be obtained from the Ohio Academy of General Practice, 209 South High Street, Columbus 15, Ohio.

The American Board of Obstetrics and Gynecology (Part II) oral and clinical examinations for all candidates eligible will be conducted at the Edgewater Beach Hotel, Chicago, May 7-17.



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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. C. H. Bell, 754 Dickson Parkway, Mansfield
(See Page 281 for roster of officers.)

CLARK COUNTY

The Woman's Auxiliary of the Springfield Dental Society was hostess at a combined luncheon meeting with the Woman's Auxiliary of the Clark County Medical Society on January 23 at the Springfield Country Club.

Mrs. H. Z. Dredge, president of the Dental Society Auxiliary, was the presiding officer for the 45 members of the Medical Auxiliary and 26 members of the Dental Auxiliary. Mrs. George Peters was general chairman with Mrs. John Baldwin and Mrs. D. D. Glendenin in charge of table decorations and hospitality. Miss Joyce Hurley, representative of the DuBarry Co., was the speaker for the afternoon and her subject was "Let's Be Beautiful."

Special guests were Mrs. V. R. Frederick, President of the Woman's Auxiliary to the Ohio State Medical Association, and Mrs. H. V. Gieringer, President of the Woman's Auxiliary of the Ohio State Dental Society.

COLUMBIANA

The Woman's Auxiliary to the Columbiana County Medical Society met for dinner at the Masonic Temple in Lisbon on January 22. Twenty members were present with Mrs. V. C. Hart, president, presiding for the business meeting.

The Auxiliary has been very active the past few weeks in its civic projects. The safety committee chairman announced that Mrs. V. C. Hart and Mrs. C. J. Lehwald were at Swartz Store in Salem on December 6 and 13 to distribute safety pamphlets and wallet-size health cards. The ladies also solicited blood donors for the Bloodmobile in Salem. Mrs. William Horger announced that over 300 cards had been distributed in East Liverpool. These folders will be available to Lisbon residents.

The East Liverpool members are sponsoring a Home Preparedness Group as part of the Civil Defense program.

It was voted to donate $300.00 to the A.M.E.F.

Mrs. Hart and Mrs. W. Banfield were appointed delegates to the convention in Cincinnati with Mrs. Horger as alternate.

Mrs. A. P. Falkenstein, program chairman, introduced Mrs. Wade Bacon, who gave a five-minute promotional talk on *Today's Health*. Mrs. Falkenstein then introduced Mrs. Guy Byers of Salem. Mrs. Byers is a well known veteran in the art of giving a book review. She reviewed *All I Want is Everything*, by Martin Mill Preminger. Mrs. Peter Cibula of Lisbon was hostess for the meeting. Members of the Eastern Star served the dinner.

CUYAHOGA

The Chrysanthemum Ball was a crowning success and netted $700.00 profit which will help AMEF, Nurse Recruitment and the Adolescent Project at Cleveland State Hospital. Chrysanthemums to all the Auxiliary women who worked on the project.

The Auxiliary has been asked again this year to perform at the annual meeting of the Academy in May. A call has gone out for members to try out for parts in a skit "The Mink Coated Pill."

Mrs. Fred Kelly, public relations chairman, served on the planning committee when the Institute on Inter-professional Planning for Disaster Relief held a cocktail party and dinner at the Hotel Carter on January 29. Mrs. James Kendrick, Civil Defense chairman and Mrs. Roscoe Kennedy, Auxiliary president, acted as hostesses.

Two years ago the Auxiliary's Stay at Home project netted AMEF $2000. Mrs. C. A. Colombi has now received requests for plans of the event from all over the country, and *Good Housekeeping* magazine printed the story in its February issue, in the section which they call "The Better Way."

ERIE

"Public Health in Our Community Today" was the program topic for the January meeting of the Woman's Auxiliary to the Erie County Medical Society. Miss Juanita Mathews, supervisor of Erie County public health department's nursing service was the speaker, and was introduced by Mrs. E. P. Gillette, Jr., program chairman. Miss Mathews described the humanitarian and professional variety of work involved in the daily routine of the department personnel.

Luncheon at the Business Women's Club preceded the afternoon meeting. Mrs. W. P. Skirball conducted the meeting and Mrs. C. R. Lavendar reported on the progress of the auxiliary's Essay contest.

HAMILTON

An interesting calendar of entertainment is being planned for the convention of the Woman's Auxiliary to the Ohio State Medical Association, April 14-17, by its Cincinnati hostesses. The

Hamilton County Auxiliary, through its convention co-chairmen, Mrs. Charles W. Hoyt and Mrs. Carl F. Schilling, has arranged a luncheon honoring the doctors on Tuesday, April 15, at which Marian Spellman, lovely blonde singing star of television, will entertain. A cocktail hour and luncheon on Wednesday, April 16, will be climaxed by a spring fashion show. A hospitality room will be open each day to provide a congenial social center for meeting friends.

At the Auxiliary's luncheon meeting on January 21, approximately 250 members and their guests heard Dr. Maurice Levine, professor of psychiatry at the University of Cincinnati College of Medicine, speak on "The Care and Feeding of Husbands, or Psychotherapy in Medical Wives Practice."

The Auxiliary heard the Rev. Lynn J. Radcliffe, pastor of the Hyde Park Community Methodist Church, speak on "Healing Ill Health from Within." His talk followed a luncheon at the Cincinnati Club at which the president, Mrs. Gaston B. Hannah, accorded grateful recognition to the group of physicians' wives who have organized and directed Future Nurse Clubs in 11 Greater Cincinnati high schools. Their efforts have been extended to include all related careers in health, and have stimulated the interest of more than 300 high school students this year.

The second in a series of orientation meetings for new members was held on January 29 at the home of Mrs. Roy L. Kile.

MAHONING

A talk by Dr. Leonard Lovshin of Cleveland Clinic staff marked the January meeting of the Woman's Auxiliary to the Mahoning County Medical Society at the Youngstown Club. In discussing his topic, "The Tired Mother Syndrome" the speaker described fatigue as the most common complaint of the modern mother and housewife, and illustrated his talk with slides and amusing cartoons. Mrs. Kenneth Hovanic, co-chairman of the program introduced Dr. Lovshin. Special guests were Mrs. Lovshin and Dr. Andrew A. Detesco, president of the Mahoning County Medical Society.

Mrs. Cary Peabody, president, presided and Mrs. Wayne Agey gave reports of medical legislation now pending in congress. Mrs. W. K. Allsop was lauded for her work as safety chairman and a motion was made to send a contribution of $300 to the American Medical Education Foundation.

Mrs. Peabody, Mrs. Earl Young, Mrs. Paul Mahar and Mrs. H. E. Hathhorn were announced as delegates to the State convention to be held in April in Cincinnati. Alternates will be Mrs Asher Randell, Mrs. C. W. Stertzbach and Mrs. Craig Wales.

Fifty members were in attendance for the meeting. Flowers from the table were sent to Mrs. Wayne B. Hardin, program chairman for the evening, who at that time was a patient in South Side Hospital having suffered a broken leg in a recent skiing accident.

RICHLAND

Dr. Paul Carter was guest speaker when members of the Woman's Auxiliary to the Richland County Medical Society convened at the Mansfield Leland Hotel for luncheon on January 6.

Dr. Carter's topic concerned a Social Study of Mansfield and Richland County. Following the program, Mrs. Paul Lee, president, conducted the business meeting. Mrs. Carl Damron reported on Ways and Means. Total receipts were given for the sale of candy, tea towels, sales tax stamps and the Silent Auction held recently. Proceeds will be divided between the American Medical Education Foundation and Nurse Scholarship Fund.

Hostesses for the day were Mrs. Hall Wiedemer, Mrs. Charles Shafer, Mrs. Oscar Klein and Mrs. W. W. Peirce.

ROSS

"Stork Club," a class in prepared motherhood sponsored by the Woman's Auxiliary to the Ross County Academy was scheduled to begin a series of four lessons at the old hospital building. The announcement was made at the auxiliary meeting and dinner held on January 9 at the Lynne House. Mrs. Robert Swank presided at the meeting, Mrs. Edward Artman introduced Mr. Omen Oakes, city fireman who spoke on fire prevention.

Mrs. H. M. Crumley reported that the Health Career Club would be held at the Chillicothe High School. A representative from Jewish Hospital in Cincinnati will be guest speaker. She will be accompanied by a Chillicothe girl now in training at the hospital.

Mrs. Robert Giesler reported that plans are being made for a radio program. Mrs. Artman reported on the new brochure devised for the Chillicothe Hospital. Mrs. David McKell was appointed chairman of the exceptional child program.

Mrs. John Franklin, Sr., presided at the Hospital Guild I meeting which followed.

SCIOTO

Mrs. David Heusinkveld of Cincinnati, district organizer of the League of Women Voters, showed slides taken during her visit in 1956 to Russia at a meeting of the Woman's Auxiliary to the



when you encounter

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2. High degree of freedom from annoying or therapy-interrupting side effects.

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Sumycin Capsules (per Capsule)	250	Bottles of 16 and 100
Sumycin Suspension (per 5 cc.)	125	2 oz. bottles
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Scioto County Medical Society held in the nurses dormitory of Mercy Hospital on January 15. Mrs. Heusinkveld toured Russia with a Sherwood-Eddy Educational Tour. The tour included interviews with government officials in several countries.

Members of the Portsmouth League of Women Voters were guests for the meeting. Mrs. Milton Levine presided at the table during the social hour.

Mrs. A. D. Bushman was welcomed as a new member during a business meeting conducted by Mrs. W. C. Hugenberg, president. Mrs. Joseph Gohmann, chairman of nurse recruitment, announced that the annual tea and tour of Mercy Hospital and the School of Nursing would be held to promote interest in nursing among freshman and sophomore girls of the area. Tickets for the spring style show were distributed to members by Mrs. Jack MacDonald and Mrs. Otto F. Apel, Jr.

Hostesses for the meeting were Mrs. Levine, Mrs. Sol Asch, Mrs. Ralph Lewis and Mrs. Jerome Rini.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for a luncheon meeting January 7 at the Fairlawn Country Club. Mrs. R. R. Pliskin, president, presided over the business meeting. She reminded everyone of the coming 11th Annual Health Days to be held March 7-8- and 10 in Akron at O'Neil's Auditorium. Mrs. J. W. Parks is chairman and Mrs. E. L. Mollin is co-chairman. Mrs. H. W. Allison, program chairman, introduced the speaker, Kenneth Nichols. Mr. Nichols is a columnist for the *Akron Beacon Journal* and the title of his talk was "But the Doctor Died."

On January 25 the Auxiliary co-sponsored a half-hour television program on WAKR Channel 49 in Akron. Mrs. F. A. Ruoff was chairman. The script "It Could Be You" was acted by the Players of the University of Akron. This was given in cooperation with the Poison Control Center at Children's Hospital in Akron.

STARK

Mrs. W. H. Schumaker was chairman for the dessert bridge of the Woman's Auxiliary to the Stark County Medical Society on January 21 at the Garden Center. Mrs. John Thomas served as co-chairman.

Mrs. Richard G. Spitzer presided at the business meeting. The Auxiliary voted to sponsor in the County High Schools the 12th annual essay contest which is a national project of the Association of American Physicians and Surgeons' Freedom Programs Inc. The top prize in the contest is $100. Part of a nationwide program, the contest will offer prizes for the three best essays written on one of two subjects: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." Second prize will be $50 and third $25. All three top essays will be entered in the national competition sponsored by the Association. Sons and daughters of physicians are not eligible to enter the contest.

Mrs. Howard Ickes is chairman of the local program which has been approved by the superintendents of the Canton and Stark County school systems. Fifty-two members of the Auxiliary are now visiting the 26 high schools to distribute information and posters about the contest. Canton Public Library is cooperating with the Auxiliary in providing resource material for the contestants. In the national contest a total of $2675 will be awarded for the best entries with $1000 for the first prize winning essay.

A white elephant auction for the benefit of the American Medical Education Fund was held preceding the meeting, with Mrs. Mark Herbst as auctioneer, and netted $90 for AMEF.

TRUMBULL

The regular monthly meeting of the Auxiliary to the Trumbull County Medical Society was held on January 16 at the Trumbull Country Club. Following a buffet luncheon, the business meeting was conducted by Mrs. Clyde W. Muter, president. Honorary members and special guests were introduced and welcomed. The announcement was made for the date of the annual Gardenia Ball.

Speaker for the afternoon was Mr. Robert H. Johnston, a former F. B. I. agent.

Hostesses for the afternoon were Mrs. P. J. Fusco and Mrs. E. J. Datesh.

TUSCARAWAS

Nineteen members of the Woman's Auxiliary to the Tuscarawas County Medical Society met for a luncheon at Hotel Reeves on January 9. Mrs. James Zeller was a guest.

Mrs. C. R. Crawley, president, presided over the business meeting during which Mrs. H. F. VanEpps of Dover thanked the members for their cooperation in the recent Yuletide Tour which met with great success. Special appreciation was expressed to Mrs. J. R. Martin of Dover who served as chairman of the ticket sales. Mrs. W. E. Hudson, project chairman, reported on the orthopedic clinic at Union hospital at which the auxiliary assists in checking in patients. An average of 60 patients a day is received at the clinic which is conducted twice a month.

A report on the American Medical Education

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Comprehensive control of constipation with Doxan . . .

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★ synergistically provides, with a subclinical dosage, peristaltic action on a soft, "normal" intestinal content rather than on the hardened mass typical of constipation

★ results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

Doxinate with Danthron (Doxan) is supplied as brown, capsule-shaped tablets containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. 1,8-dihydroxyanthraquinone.

Usual adult dose: One or two capsule tablets at bedtime. Bottles of 30 and 100.

When fecal softening alone is indicated— Doxinate 240 mg.—provides optimal once-a-day dosage for maintenance therapy.

Doxinate is a registered trademark of Lloyd Brothers, Inc.

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Fund was given by Mrs. J. W. Calhoon of Uhrichsville who said that $450 has been contributed through individuals in the county. A check for $89.79 was turned over to this fund from sales tax refunds. Mrs. R. J. Foster, radio and visual chairman, reported that a program on pediatrics is being broadcast over WJER each Monday at 11:30 A. M.

Mrs. Hudson was chairman of the luncheon committee which included Mrs. Burrell Russell and Mrs. E. C. Davis.

The Nurses' Loan Fund of the Auxiliary was augmented substantially when more than one thousand persons made the Yuletide Tour arranged by the organization in December. The tour one of the most ambitious projects ever staged by the Auxiliary, took the patrons into five homes in the community where they were able to view a wide variety of decorations appropriate for all types of architecture and home decor. Along with the decorative ideas those making the tour were able to pick up gift and holiday food suggestions from the large displays through the courtesy of merchants and business concerns in the area.

Some New Instructions About Medicare Program

Ohio physicians will want to acquaint themselves with the following recent information concerning the Medicare Program, this information coming from both the Medicare headquarters in Washington and from Mutual of Omaha, fiscal agent for Medicare in Ohio.

Medicare headquarters at Washington recently issued the following directive concerning the Uniformed Services Identification and Privilege Card (DD Form 1173):

1. Instructions published by each of the Uniformed Services for the preparation and issuance of Identification Cards (DD Form 1173) vary in detail as to the method of indicating eligibility for medical care in Item 14 of the Form. The various methods prescribed are as follows:

a. The word "Yes" will be inserted preceding the word **Civilian** and/or **Uniformed Services.**

b. The word "Yes" will be inserted following the word **Authorized.**

c. The word "Yes" will be inserted without specifying location within Item 14.

(Continued on Next Page)

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d. The letter "X" indicating yes will be inserted without specifying location within Item 14.

2. All instructions provide that, if an individual is not eligible for civilian care, the word "Civilian" is to be blocked out.

3. Uniformed Services Identification and Privilege Cards that were issued to eligible spouses and children in accordance with any of the above methods and on which the word "Civilian" is not blocked out are acceptable for Medicare identification purposes. The same degree of caution, as previously expressed in paragraph 5 of ODMC Letter No. 23, wherein an identification card may erroneously reflect that a person other than an eligible spouse or child is entitled to civilian care, must be exercised irrespective of whether the word "Civilian" is blocked out on the DD Form 1173.

From Mutual of Omaha come the following corrections in the Ohio Physician's (Medicare) Fees and Procedure Guide:

A. Page 17, paragraph 5, Emergency Care: First sentence should read: "Inpatient care is authorized in acute emergencies of any nature which are a threat to the life, health, or well-being of the patient."

B. Page 27, code 0266—each additional ½ inch—$2.50.

C. Page 25, code 006, 007, 0010—all pertain to neo-natal care. Not more than two (2) visits are payable and these must be accomplished within the first 60 days.

Mutual of Omaha reports that for the calendar year 1957, its 12,454 medical claims in Ohio were processed for payment and that the total paid amounted to $943,604.07.

OMI Making Survey To See How Schedule Can Be Improved

Ohio Medical Indemnity, Inc., is making a survey among some 22,000 of its subscribers who have filed claims recently with OMI to ascertain the amount of the physician's charge.

This is being done to find out how close the indemnity payments of OMI are to the physician's charges in the average case, so upward revisions can be considered for those items found to be too far out of line.

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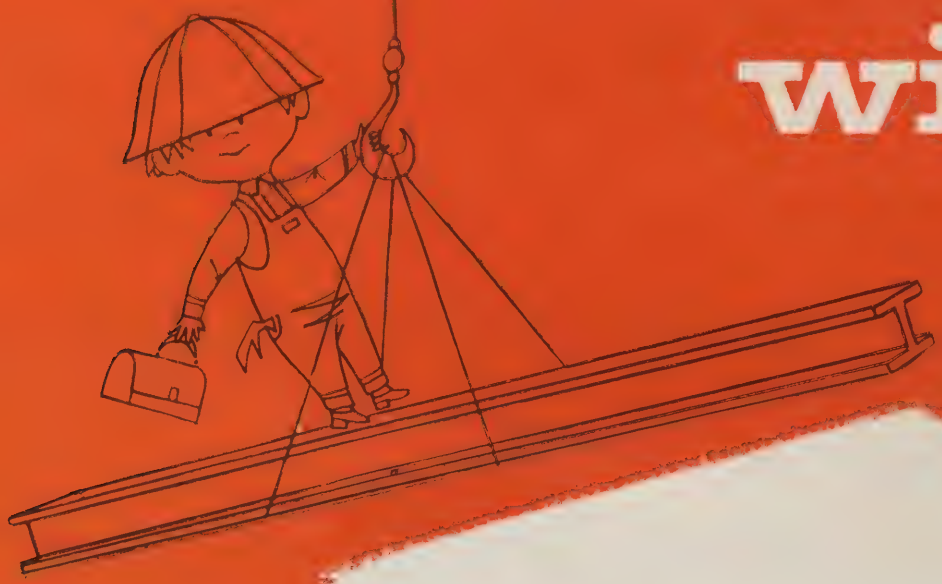
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B_1	2000%	1333%	1000%
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l-Lysine HCl	300 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine Mononitrate (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	0.75%

Average dosage is one teaspoonful daily. Available in bottles of 4 fl. oz.

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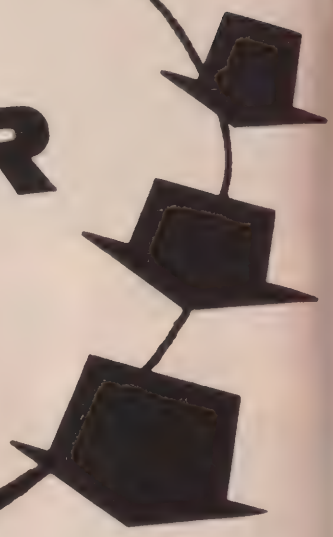
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with each Rx Specific Desensitization Set prepared according to your patient's own skin test reactions.

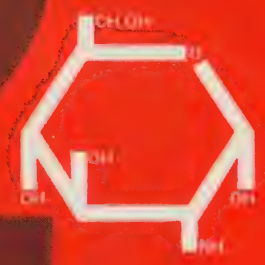
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The Sherman Act and the Practice of Medicine

Is the practice of medicine "trade or commerce," and, if so, is it trade or commerce of an interstate character so as to be amenable to the restrictions of the Sherman Anti-Trust Act? The answer to this question has been hinted at in a few court decisions. Now the United States Court of Appeals for the Eighth Circuit has faced the issue squarely and the conclusion reached is of considerable interest and importance to the entire medical profession.

Dr. Frank Riggall, a duly licensed physician and surgeon in Washington County, Arkansas, having been denied membership in the county society, sued that society and a number of its members for treble damages under the provisions of the Sherman act. He alleged, among other things, that in the course of his practice he received, accepted, treated, and administered to patients from Arkansas, Oklahoma, Kansas, Missouri, Texas, and other states, and that but for his denial of membership in the Washington County Medical Society he would have done so to many more patients. This, he alleged, would have been of great economic benefit and importance to him as well as to his patients, the public, and society in general. All of this he contended substantially affected trade and commerce between the state of Arkansas and other states and constituted a conspiracy to restrain interstate commerce.

The trial court held that it was without jurisdiction and dismissed the complaint without taking any evidence. The court of appeals first noted that the complaint was confined to the plaintiff's private medical practice and charged no economic burden on the public. There was no allegation that the rejection of the plaintiff's application for membership in the county society resulted in the raising or fixing of fees charged the public by other physicians. There was no allegation in the complaint remotely suggesting that the acts of the defendants cast any burden upon interstate commerce. The mere fact, said the court, that the plaintiff at his location in Arkansas may be treating patients from other states who must travel interstate does not result in his practicing his profession in interstate commerce. The practice of his profession, as disclosed by the allegations in his complaint, was neither trade nor commerce within section 1 of the Sherman Anti-Trust Act, nor were there any allegations in the complaint indicating that the actions of the defendants resulted in a monopoly within the provisions of section 2 of the Sherman act.

Finally, the court said that the plaintiff was not prevented from practicing his profession. His complaint, in substance, was that the practice of his profession would have been more profitable to him had he not been deprived of membership in the Washington County Medical Society. The court pointed out, however, that the Sherman act was not enacted primarily to protect the individual but to protect the general public economically, and a private party may not recover under the act unless there has been an injury to the general public economically.

On November 15, 1957, the court of appeals, therefore, held that, on the facts set forth in the plaintiff's complaint, the practice of medicine was not trade or commerce and that the defendants had not combined or conspired to monopolize trade or commerce among the several states. The trial court was therefore held to be without jurisdiction and the complaint was properly dismissed.

This decision would seem clearly to support the proposition that a medical society which, in good faith, denies membership to a local physician in private practice, even though that physician treats patients who come to him from other states, is not subject to the payment of damages in a civil suit under the Sherman Anti-Trust Act.—*Journal of American Medical Association,* Jan. 4, 1958.

Approve Location for New Ohio Rehabilitation Center

Location of the proposed new Ohio Rehabilitation Center on Ohio State University property, south of the Health Center, has had the approval of the Ohio State University Board of Trustees.

The new center, for which Ohio Legislative appropriations total $1,015,000, will be located adjacent to the east boundary of university property near Perry St. and north of Eighth Ave. extended.

Federal funds, which include Hill-Burton money and National Institute of Health grants for research facilities, bring the amount available for the new structure to about $1,250,000.

The rehabilitation program, which has been housed in the Health Center since its creation in October 1952, now occupies space in the Ohio Tuberculosis Hospital. The new center will not only permit increased service to severely disabled persons, but provide an expanded program of education and research in cooperation with the university.

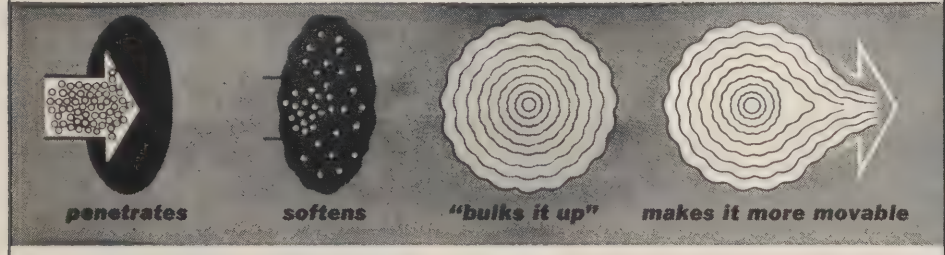
A three-member board of control directs the rehabilitation program. Members are President Novice G. Fawcett of Ohio State University; Dr. Ralph E. Dwork, director of the Ohio Department of Health; and the public representative on the State Industrial Commission, J. Maynard Dickerson. Dr. Ralph E. Worden is the medical director.

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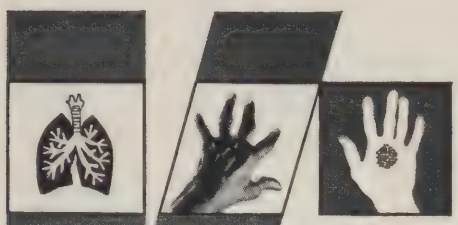
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* J.A.M.A. *166*:158,1958; Welsh, A.L. and Ede, M. "... *prompt remissions of ... acute phases.*" with TARCORTIN

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5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

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THE ORIGINAL MEPROBAMATE

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Anxiety of pregnancy

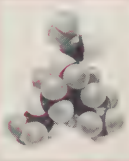
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**Belafsky, H. A., Breslow, S. and Shangold, J. E.: Meprobamate in pregnancy. Obst. & Gynec. 9:703, June 1957.*

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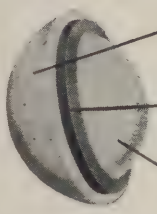
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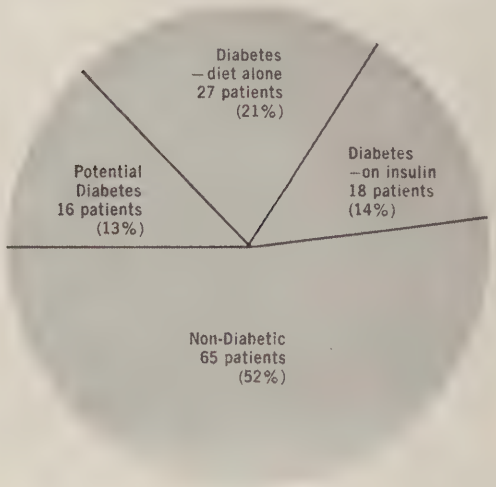
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B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
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Vitamin E	1 I.U.	Inositol	20 mg.
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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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*Murphy, R.: Connecticut M. J. *21*:306, 1957.

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Arist

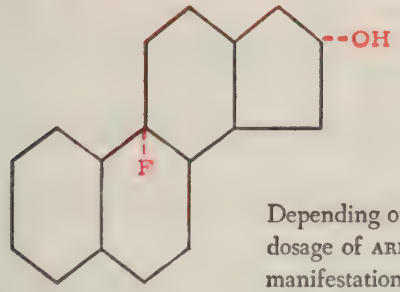
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2. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.
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11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

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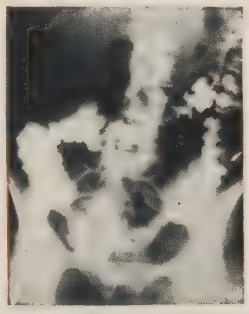
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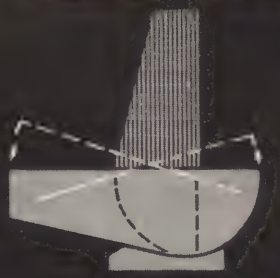
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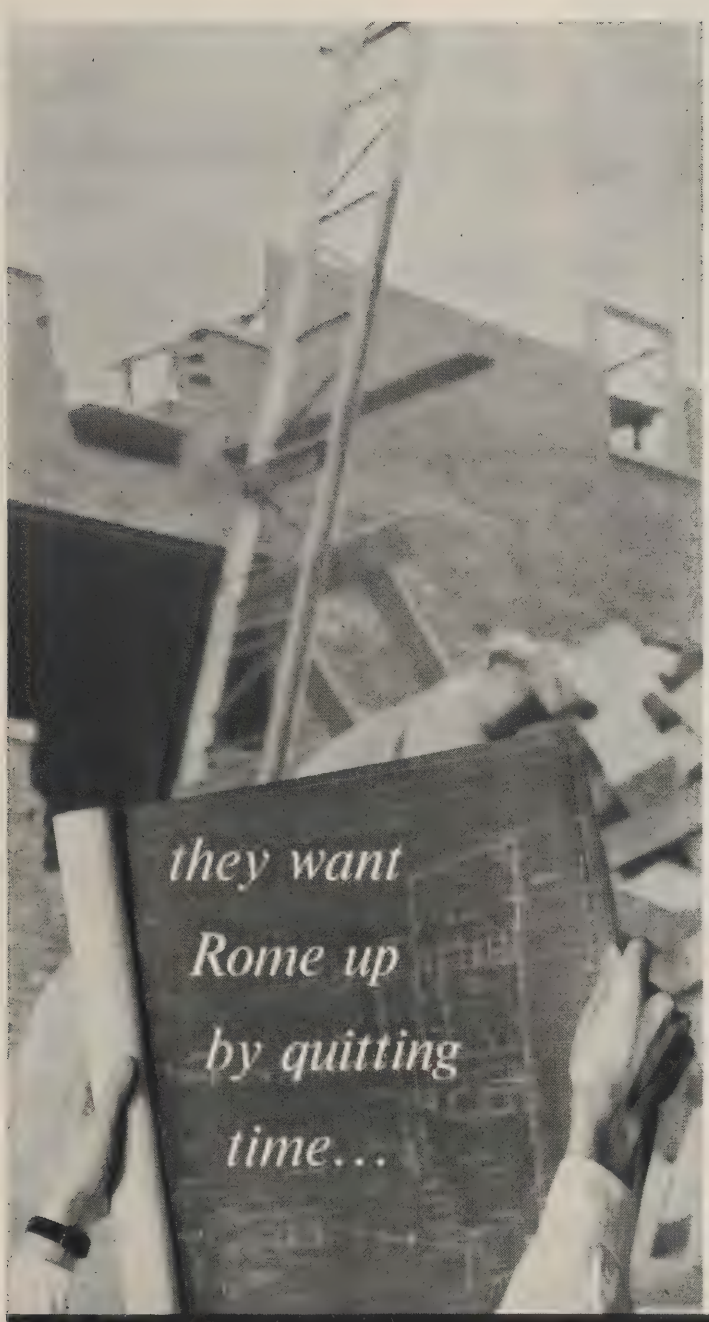
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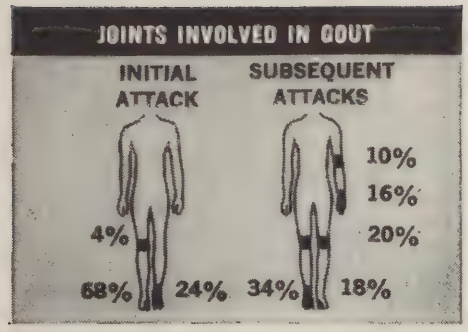
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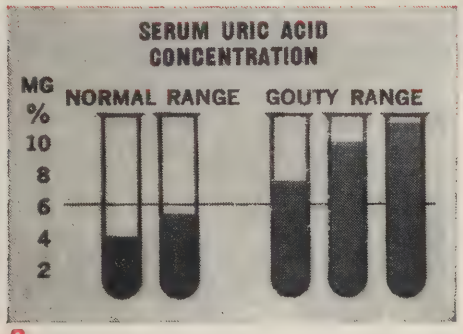
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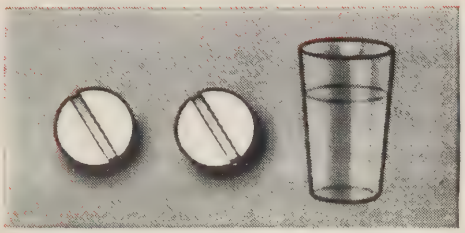
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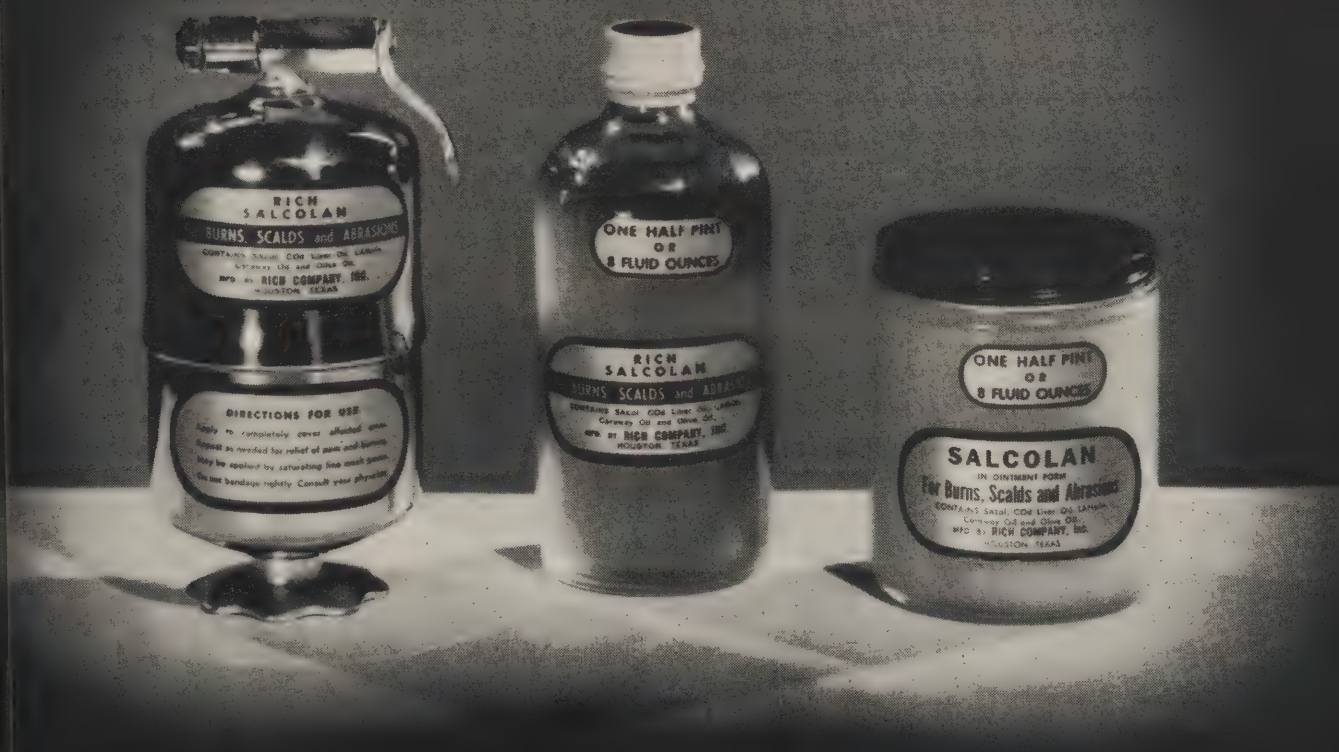
5 **How can I obtain further information on the value of corn oil as a source of unsaturated fatty acids?**

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1958 Annual Meeting, Ohio State Medical Association, Cincinnati, April 15-17.

American Medical Association, Annual Session, San Francisco, June 23-27.

American College of Surgeons, Course in Fractures and Other Trauma, Chicago, April 16-19.

Amercan Trudeau Society, 53rd Annual Meeting, Philadelphia, Pa., May 19-22; concurrent with meetings of the National Tuberculosis Association.

Fifth International Congress of Internal Medicine, Philadelphia, Pa., April 24-26.

1958 Industrial Health Conference, Atlantic City, N. J., April 19-25.

Medical Education Week, April 20-26.

Northern Tri-State Medical Association, Annual Meeting, May 8, South Bend, Ind.

Ohio Academy of History of Medicine, Taft Museum, Cincinnati, April 26.

Ohio State Heart Association, 1958 Annual Meeting, April 14, Cincinnati.

Pan American Medical Women's Alliance, Sixth Biennial Congress, Hotel McAllister, Miami, Fla., April 14-17.

Veterans Administration Clinical Conferences, Weekly on Wednesdays, 8:00 to 9:00 a. m., Cuyahoga Bldg., Cleveland.

Western Reserve University's Law-Medicine Center, two-day institute entitled, "The Mind: A Law-Medicine Problem," April 25-26.

West Virginia State Medical Association, Annual Meeting, White Sulphur Springs, W. Va., August 21-23.

Phi Lambda Kappa Award To Dr. Albert Sabin

For his work in virus diseases, particularly in the field of polio, Dr. Albert B. Sabin, professor of research pediatrics at the University of Cincinnati College of Medicine, has been given the Grand Scientific Award of Phi Lambda Kappa, national medical professional fraternity. The award is given annually to an outstanding Jewish physician who has made a significant contribution to medical science.

Dr. John Robboy, Cleveland, receives the fraternity's Service Award for giving the most help in promoting medical books for Israel.

Newly elected officers of the fraternity for 1958 include Dr. Max Omerantz and Dr. Robert Rosner of Cleveland, regional vice-presidents, and Dr. I. Z. Sibler and Dr. Carl Snyder of Cleveland, trustees.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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The Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic is offering a two-day course in Clinical Pathology. The course is open to all physicians, but is directed primarily to the interest and needs of pathologists. In addition the sponsoring group hopes that Ph. D. bacteriologists, chemists, and other qualified personnel will be interested in attending the program. The course will be given under the sponsorship of the Cleveland Society of Pathologists.

The course will be held May 15 and 16 on the fourth floor of the North Clinic Building located at Euclid Avenue and E. 93 Street. Those interested may obtain further information by writing to: Educational Secretary, The Frank E. Bunts Educational Institute, 2020 E. 93 Street, Cleveland 6, Ohio.

The course in Clinical Chemistry held in November 1957 will also be repeated in the fall of 1958.

Central Ohio Heart Group To Present Program

"The Hepatic Circulation in Disease" will be the topic of Dr. Jack D. Myers, chairman and director of medicine at the University of Pennsylvania School of Medicine, when he addresses the Scientific Council of the Central Ohio Heart Association, Wednesday, March 12. The all-day meeting will be held in Room M-100, Starling-Loving Hospital, Ohio State University, Columbus.

Opening the meeting at 10 a. m. will be a panel discussion of "Sclerosis of the Liver," moderated by Dr. Robert Zollinger. Panel members will include Dr. C. Joseph Delor, Dr. Sidney Nelson, Dr. B. H. K. Wiseman, all of Columbus, and Dr. Myers.

Following a noon luncheon at Jai Lai Restaurant, Dr. Myers will present his main address at 2 p. m. A clinicopathological conference from 3 to 4 p. m. with Dr. Myers and Dr. Emmerich von Haam presiding will complete the session.

The meeting is open to all Central Ohio physicians.

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1. Zimmerman, F. T., and Burgemeister, B.: *Arch. Neurol. & Psychiat.* 72:720, 1954.
2. Zimmerman, F. T., and Burgemeister, B.: J.A.M.A. 157:1194, 1955.
3. Zimmerman, F. T.: *Arch. Neurol. & Psychiat.* 76:65, 1956.



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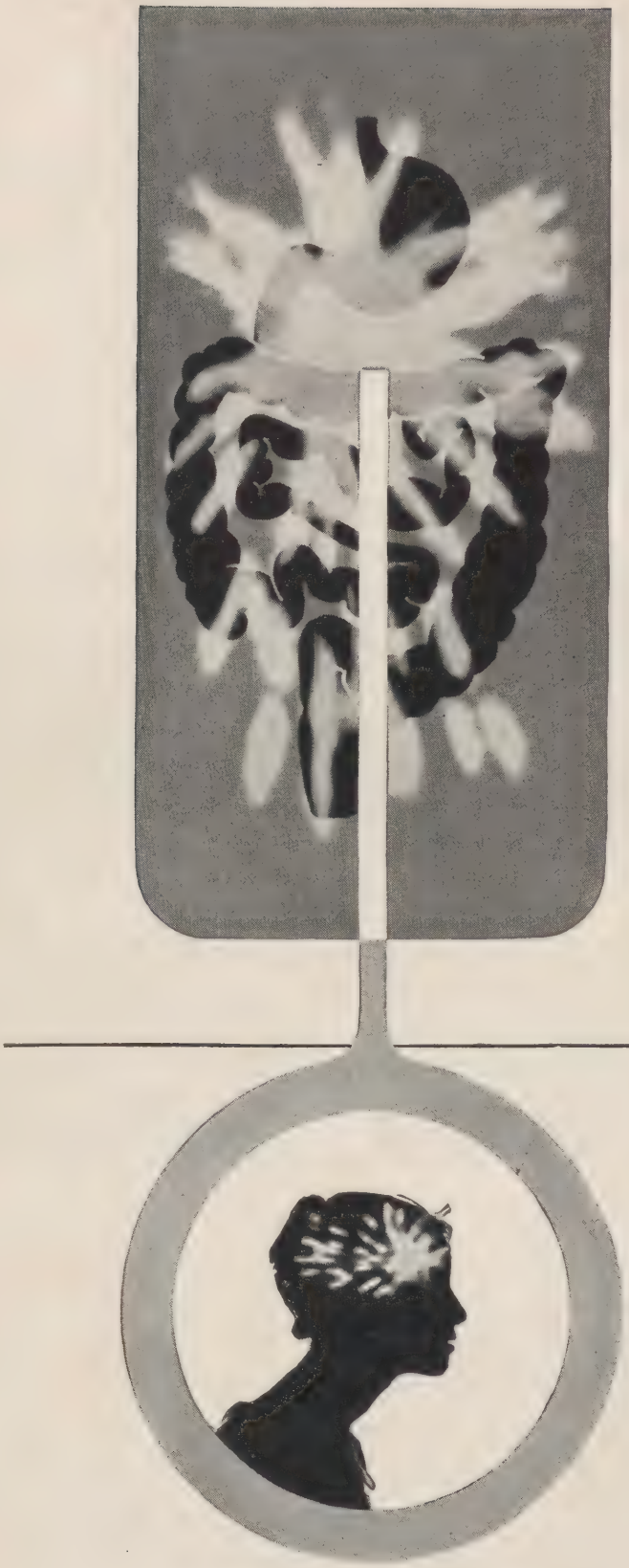
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The Ohio State Medical Journal

Vol. 54 April, 1958 No. 4

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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MARION—Daniel M. Murphy, President, Marion; James A. Schuler, Secretary, Marion. 1st Tuesday, monthly, except June, July, August.

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WOOD—Stewart J. Smith, President, Bowling Green; Richard L. Pearse, Secretary, Bowling Green.

FIFTH DISTRICT

ASHTABULA—Walter J. Brown, President, Conneaut; Robert J. Zimmerman, Secretary, Conneaut. 2nd Tuesday, monthly.

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

County Societies' Officers and Meeting Dates (Continued)

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Delesco, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown 3. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—David Danenberg, President, Bridgeport; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vorhies, Secretary, Scio. Meetings quarterly.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Snaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Don R. Johnson, President, Nelsonville; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Richard R. Hille, President, Marietta; Roy M. Meredith, Secretary, Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

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HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Robert M. Andre, President, Waverly; Mack E. Moore, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. 1st Monday after the 1st Tuesday.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Mary K. Kuhn, President, Ashley; Edward C. Jenkins, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, London; Paul G. H. Wolber, Secretary, London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Harold V. Marley, President, Ashland; Myron A. Shilling, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—Owen J. Nicholson, President, Norwalk; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Charles F. Curtiss, President, Bellville; Harlin G. Knierim, Acting Secretary, Mansfield.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.

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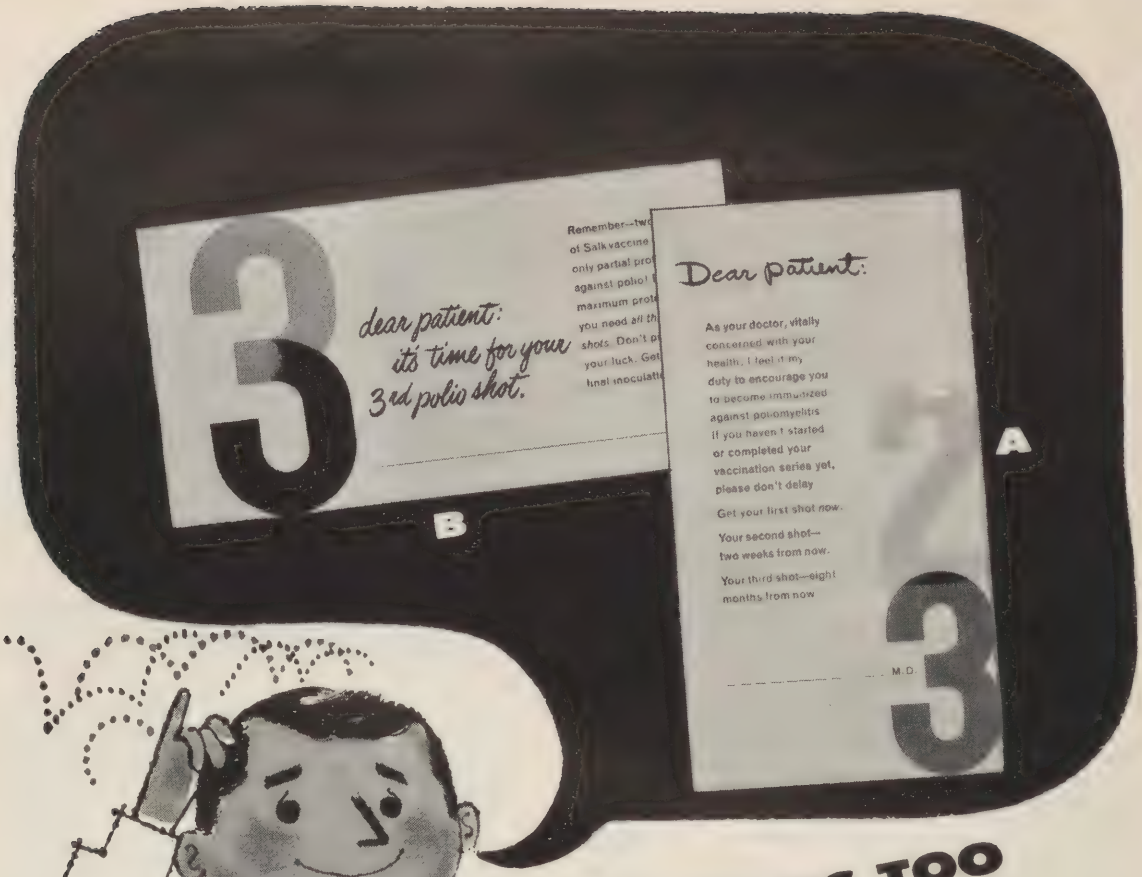
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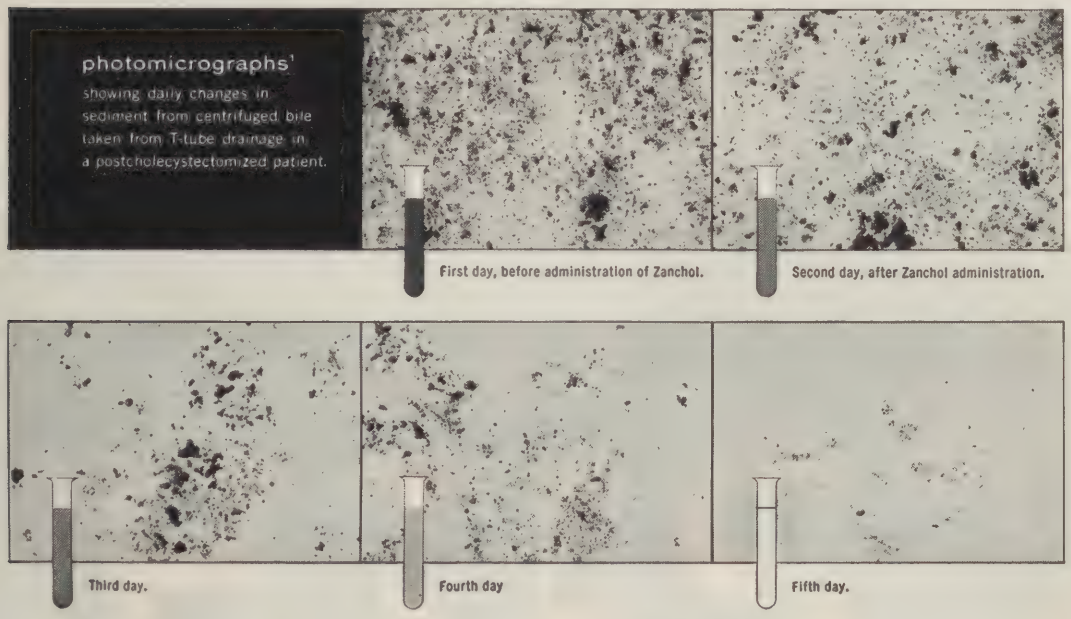
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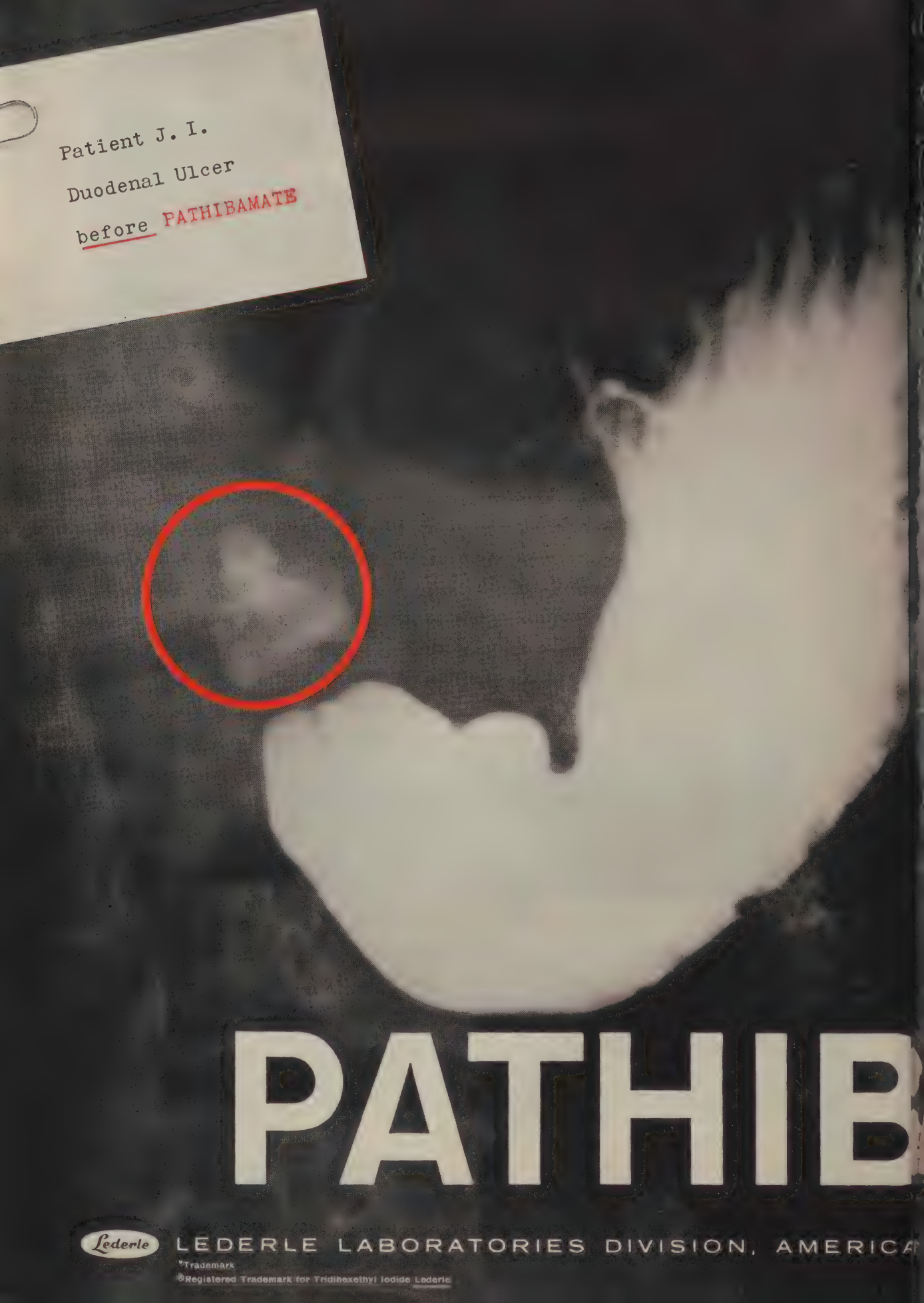
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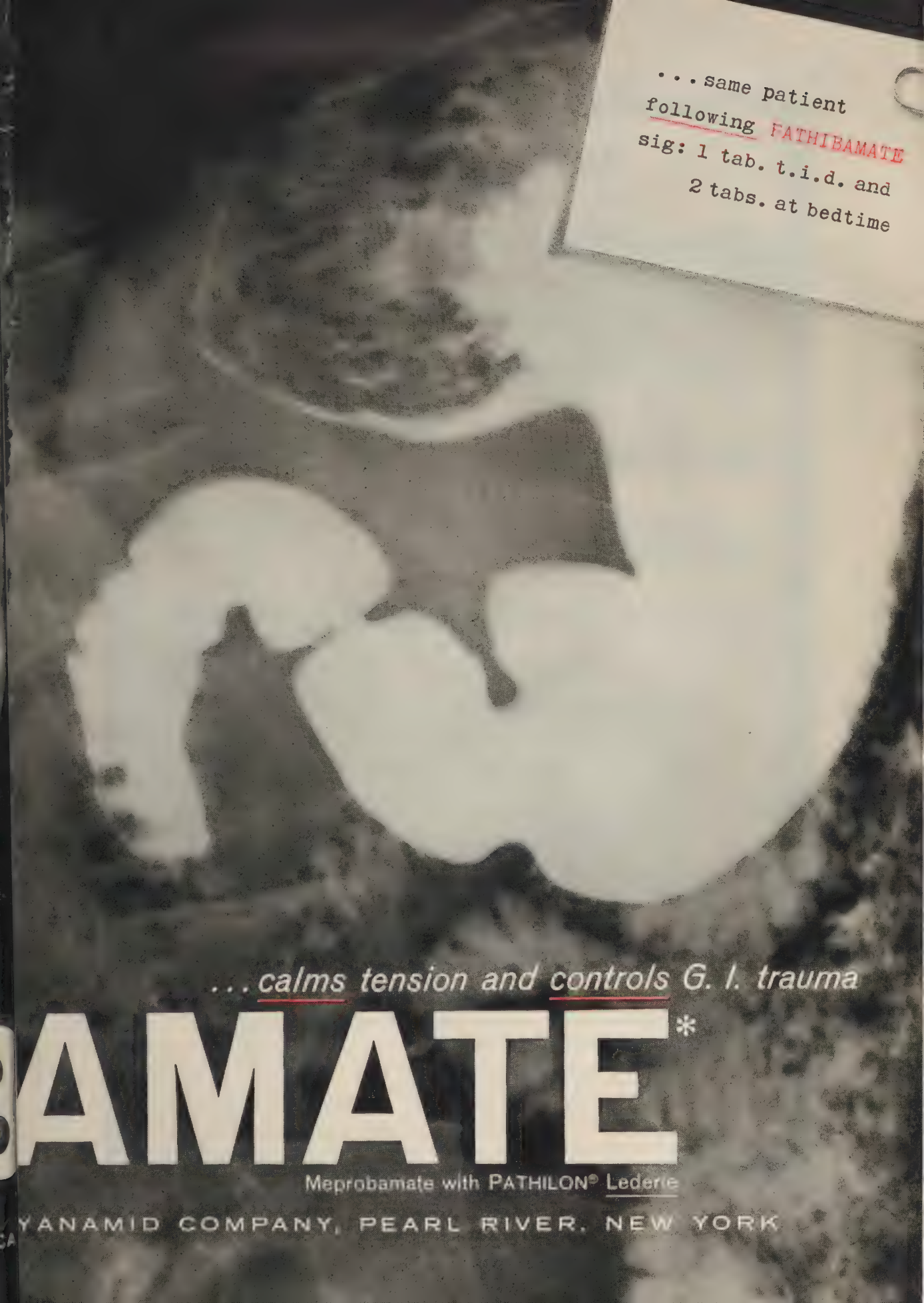
Research in the Service of Medicine.



1. McGowan, J. M.: Clinical Significance of Changes in Common Duct Bile Resulting from a New Synthetic Choleretic, Surg., Gynec. & Obst. *103*:163 (Aug.) 1956.

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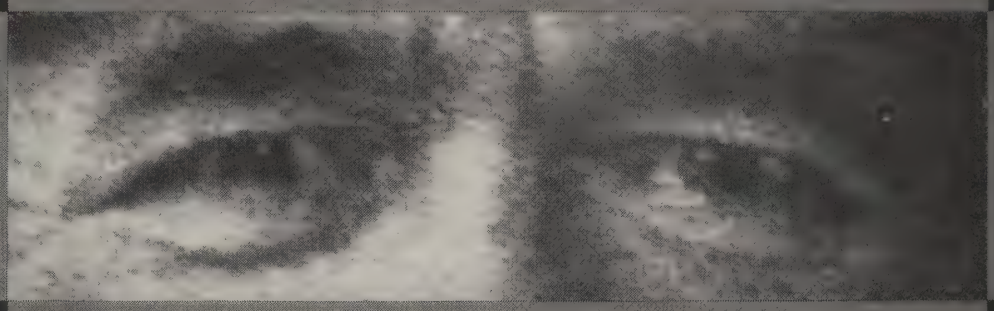
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Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: A Clinical Evaluation of Ectylurea (NOSTYN®), in press.

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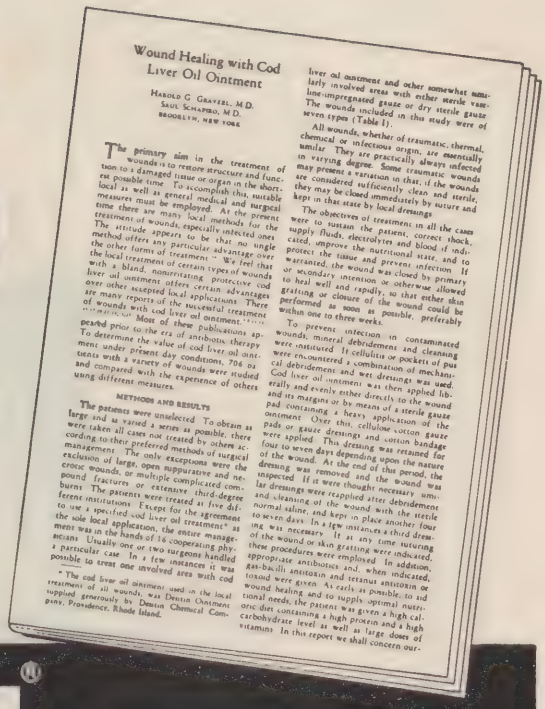
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Wound Healing with Cod Liver Oil Ointment

HAROLD G. GRAYZEL, M.D.
SAUL SCHAPIRO, M.D.
BROOKLYN, NEW YORK

The primary aim in the treatment of wounds is to restore structure and function to a damaged tissue or organ in the shortest possible time. To accomplish this, suitable local as well as general medical and surgical measures must be employed. At the present time there are many local methods for the treatment of wounds, especially infected ones. The attitude appears to be that no single method differs any particular advantage over the other forms of treatment. We feel that the local treatment of certain types of wounds with a bland, nonirritating, protective cod liver oil ointment offers certain advantages over other accepted local applications. There are many reports of the successful treatment of wounds with cod liver oil ointment [1-10]. Most of these publications appeared prior to the era of antibiotic therapy. To determine the value of cod liver oil ointment under present day conditions, 704 patients with a variety of wounds were studied and compared with the experience of others using different measures.

METHODS AND RESULTS

The patients were unselected. To obtain as large and as varied a series as possible, there were taken all cases not treated by others according to their preferred methods of surgical management. The only exceptions were the exclusion of large, open suppurative and necrotic wounds, or multiple complicated compound fractures or extensive third-degree burns. The patients were treated at five different institutions. Except for the agreement to use a specified cod liver oil treatment* as the sole local application, the entire management was in the hands of 16 cooperating physicians. Usually one or two surgeons handled a particular case. In a few instances it was possible to treat one involved area with cod liver oil ointment and other somewhat similarly involved areas with either sterile vaselin-impregnated gauze or dry sterile gauze. The wounds included in this study were of seven types (Table I).

All wounds, whether of traumatic, thermal, chemical or infectious origin, are essentially similar. They are practically always infected in varying degree. Some traumatic wounds may present a variation in that, if the wounds are considered sufficiently clean and sterile, they may be closed immediately by suture and kept in that state by local dressings.

The objectives of treatment in all the cases were to sustain the patient, correct shock, supply fluids, electrolytes and blood if indicated, improve the nutritional state, and to protect the tissue and prevent infection. If warranted, the wound was closed by primary or secondary intention or otherwise allowed to heal well and rapidly, so that either skin grafting or closure of the wound could be performed as soon as possible, preferably within one to three weeks.

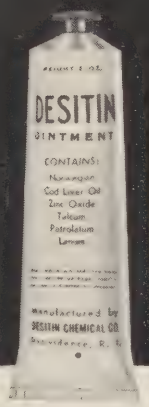
To prevent infection in contaminated wounds, mineral debridement and cleansing were instituted. If cellulitis or pockets of pus were encountered, a combination of mechanical debridement and wet dressings was used. Cod liver oil ointment was then applied liberally and evenly either directly to the wound and its margins or by means of a sterile gauze pad containing a heavy application of the ointment. Over this, cellulose cotton gauze pads or gauze dressings and cotton bandage were applied. This dressing was retained for four to seven days depending upon the nature of the wound. At the end of this period, the dressing was removed and the wound was inspected. If it were thought necessary, similar dressings were reapplied after debridement and cleansing of the wound with the sterile normal saline, and kept in place another four to seven days. In a few instances a third dressing was necessary. If at any time suturing of the wound or skin grafting were indicated, these procedures were employed. In addition, appropriate antibiotics and, when indicated, gas-bacilli antitoxin and tetanus antitoxin or toxoid were given. As early as possible, to aid wound healing and to supply optimal nutritional needs, the patient was given a high caloric diet containing a high protein and a high carbohydrate level as well as large doses of vitamins. In this report we shall concern our-

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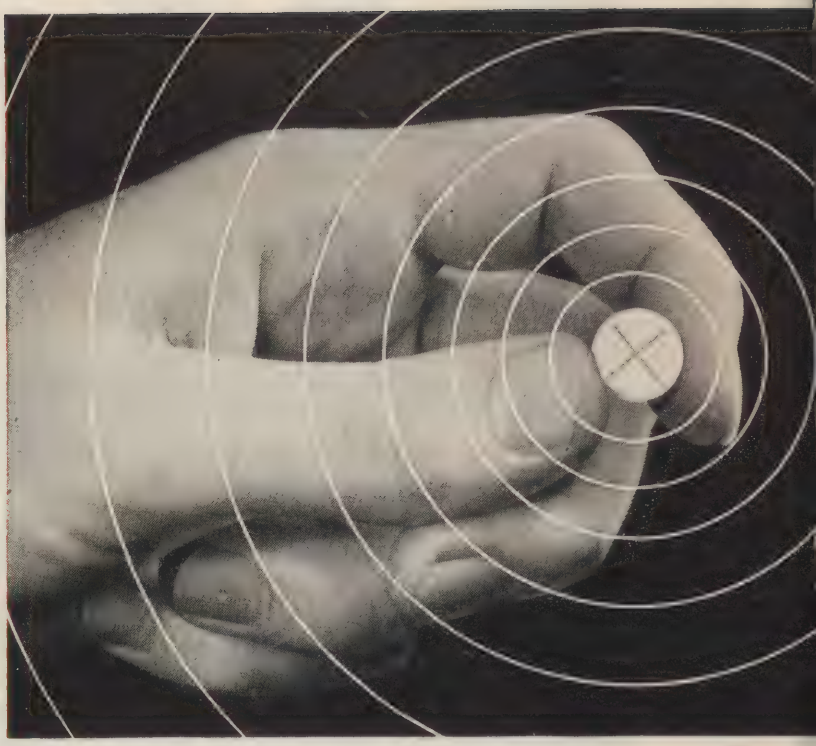
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1. Grayzel, H. G., and Schapiro, S.: Western J. Surgery, Obstet. & Gyn., Oct. 1956.

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The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

Tablets:
Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup:
Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Liver: Structure and Function, by Hans Popper, M. D., and Fenton Schaffner, M. D. ($20.00, *Blakiston Division, McGraw-Hill Book Co., New York 36, N. Y.)* This is a source book on the liver in health and disease covering both structure and function, emphasizing the correlation between clinical manifestations and pathological changes and assembling a current concept of the relation between liver structure and liver function.

The Changing Patient-Doctor Relationship, by Martin G. Vorhaus, M. D. ($3.95, *Horizon Press, Inc., 220 W. 42nd St., New York 36, N. Y.)* The author states his purpose as: "The needs of the patient can be satisfied. The doctor has, to a very large degree, the means to satisfy these needs." This study is a means to an end: that is to bring these two into the closest possible rapport with each other so that the doctor may fulfill his obligation to the patient. Among the most fascinating sections of the book are five long, detailed case histories, two women, three men (bound to be widely discussed for their frankness and for their sheer interest as human stories). It explores a need that so often preoccupies our lives—the need of both the patient and the doctor to arrive at a healthier understanding of each other. It will be interesting to a healthy person or the patient who has been troubled by his relationship with his doctor.

Dynamic Psychiatry (In Simple Terms), by Robert R. Mezer, M. D. *($2.50. Springer Publishing Co., New York 10, N. Y.)* This presentation has the merit of departing from the conventional methods of the standard texts. It puts on the printed page the material which the author has been using in teaching social workers, nurses and medical students. It portrays the development of an individual within the framework of psychoanalytical thought.

Principles and Methods of Sterilization, by John J. Perkins, M. S. ($8.00. *C. C. Thomas Inc., Springfield, Ill.)* The Director of Research for American Sterilizer Company has brought out a book of interest to all who have anything to do with the subject in any way. In addition to presenting a clear concept of the basic principles, the author has stressed the more specialized topics of which sterilization is a vital part: Planning a centralized plant in a hospital, the preparation of parenteral solutions, and infant formulae.

Natural Childbirth, by H. B. Atlee, M. D. ($2.75. *C. C. Thomas Publisher, Springfield, Ill.)* Sane presentation of a sane approach to childbirth.

The Urge to Punish, by Henry Weihofen. ($4.00. *Farrar, Straus and Cudahy, New York 3, New York.)* This is an Isaac Ray Award Book and presents a new approach to the problem of mental irresponsibility for crime.

Mental Health Planning for Social Action, by George S. Stevenson, M. D. ($6.50, *The Blakiston Division of McGraw-Hill Book Co., New York 36, N. Y.)* This book offers new perspectives to those who are concerned with mental health. It enables them to make the most of the existing facilities and to work closely with other groups toward the common goal.

Heritable Disorders of Connective Tissue, by Victor A. McKusick, M. D. ($7.50, *C. V. Mosby Co., St. Louis 3, Mo.)* This is addressed to the general man—practitioner, pediatrician and internist—for he is in the best position to size up the total situation with reference to the patient and to his family. The text treats of the normal; then Marfan Syndrome; Ehlers-Danlos Syndrome; Osteogenesis imperfecta; Pseudoxanthoma elasticum; Hurler Syndrome; and several of the lesser well known changes in connective tissue.

Doctors, Dynamite and Dogs, by Edith M. Schussler. ($5.00, *Caxton Printers, Caldwell, Idaho.)* The story of the exciting days when the Milwaukee, St. Paul and Puget Sound Railroad was extending itself westward from St. Regis, Montana, to St. Joe, Idaho, by digging the St. Paul Pass Tunnel through the Bitterroot Range and the part that the author and her husband, the contract surgeon, played out there.

Diagnosis and Treatment of Vascular Disorders—Angiology, by Saul S. Samuels, M. D. ($16.00. *The Williams and Wilkins Co., Baltimore 2, Md.)* This is a well rounded source book reflecting the current status of all phases of the disorders of the blood vessels by the editor of *Angiology.*

Textbook of Gynecology, by Emil Novak, M.D., and Edmund R. Novak, M. D. ($11.00, fifth edition, *Williams and Wilkins Co., Baltimore 2, Maryland.)* Special emphasis in the revision has

been placed upon the newer developments in the management of uterine cancer and tuberculosis. The rest of the book has received careful revision and improvement throughout.

Meditations on Medicine and Medical Education—Past and Present, by I. Snapper, M. D. (*$3.75, Grune and Stratton, New York 16, N. Y.)* The author is extremely well fitted through his education and cosmopolitan experiences to attempt to paint in the historical background of modern medicine and to show thereby where we physicians came from and possibly a hint as to where we are going.

Arthroplasty, by St. J. D. Buxton, F. R. C. S. (*$6.00. J. B. Lippincott Co., Philadelphia 5, Pa.)* This is an extension of the author's lecture to commemorate the life and works of Robert Jones.

Growing up to Love, by H. Clair Amstutz, M. D. (*$2.50, Herald Press, (Mennonite Publishing Co.,) Scottdale, Pa.)* This is a guide for parents.

Handbook of Histology, by Karl A. Stiles, (*$3.00, 4th edition, Blakiston Division, McGraw Hill Book Company, New York 36, N. Y.)* The enthusiastic reception and wide use of the three previous editions of this handbook have demonstrated that it is making a definite contribution to the teaching of microscopic anatomy.

Clinical Memoranda on Economic Poisons, prepared by Technical Development Laboratories Technology Branch, Communicable Disease Center Savanah Georgia. Reproduced as a public service by *(National Agriculture Chemicals Association Washington 6, D. C.* Apply.) This book does not deal with the long time accumulated effects of small doses injested as food residues but rather the acute and chronic poisoning of industrial user.

Morals in Medicine, by Thomas J. O'Donnell, S. J. (*$3.75, The Newman Press, Westminster, Maryland.)* The Professor of Medical Ethics at Georgetown University School of Medicine has a completely new textbook giving straightforward answers to practical problems in this field and at the same time underlines and clarifies the governing theological foundations.

Alcoholism, edited by George N. Thompson, M. D. (*$9.50, C. C. Thomas, Springfield, Ill.)* Eight authorities were sought out by the publisher and the editor to contribute their section to this medical survey of this important health problem. Alcoholism is here discussed from every angle. The authors emphasize that alcoholism exceeds heart disease and cancer in its importance to the welfare of the patient and the social structure.

Medicine in a Changing Society, Lectures to the Laity, No. XVIII, The New York Academy of Medicine, edited by Iago Galdston, M. D. (*$3.00, International Universities Press Inc., New York 11, New York.)* This is another in the series under this general title which points up, in language that any literate person can understand, the basic structure of medical research in the field of mental health as it is related to the challenging problems of emotional adjustments in a changing order of society.

Synopsis of Pathology, by W. A. D. Anderson, M. D. (*$8.75, 4th edition, C. V. Mosby Co., St. Louis 3, Mo.)* A concise but comprehensive presentation of pathology.

Cytologic Technics for Office and Clinic, by H. E. Nieburgs, M. D. (*$7.75, Grune and Stratton, Inc., New York 16, N. Y.)* Cancer detection and diagnosis has been greatly enhanced by the study of exfoliative cytology. This volume presents the accumulated data on cell morphology, techniques of cell collection, the preparation of specimens and laboratory procedures.

Manual of Recovery Room Care, edited by John M. Beal, M. D. (*$3.75, Macmillan Co., New York 11, N. Y.)* A manual by members of the Department of Surgery, The New York Hospital Cornell Medical Center for all who are responsible for postoperative patients.

Clinical Use of Radioisotopes, by W. H. Beierwaltes, M. D., P. C. Johnson, M. D., and A. J. Solari, M. S. (Physics). (*$11.50, W. B. Saunders Co., Philadelphia 5, Pa.)* Developed at Ann Arbor in an effort to reduce the load of repetitive teaching. It attempts to instruct in the common clinical uses of these new therapeutic materials.

Book of Health: An Authoritative Family Guide, edited by W. W. Bauer, M. D. (35 cents, *Dell Books, New York 10, N. Y.)* The official American Medical Association Book of Health.

Notes on Atomic Energy for Medical Officers, (*$4.75, Philosophical Library, Inc., New York 16, New York.)* An introduction to the subject for Service and other Medical Officers who may be concerned with defense against atomic bombs and similar problems, by The Royal Naval Medical School, Alverstoke, Hampshire, England.

Drugs in Current Use: 1957—Third Vol., edited by Walter Modell, M. D. (*$2.00, Springer Publishing Co., Inc., New York 10, N. Y.)* This

is an annually revised alphabetical listing of drugs in common use; well established drugs, some still on trial, old ones of only traditional value but likely to be encountered.

Manual of Anesthesiology, by Herman Schwartz, M. D., S. H. Nagi, M. D., E. M. Papper, M. D. ($4.25, *C. C. Thomas, Springfield, Ill.)* A text for residents and medical students presenting condensed but complete source of primary and basic information.

Concise Anatomy, by Linden F. Edwards, Ph. D ($7.50, second edition, *McGraw Hill Book Co., New York 36, N. Y.)* This book is designed for students in the allied health areas, who must know the basic principles of human anatomy.

Ready for the Plaintiff, by Melvin M. Belli. ($6.50, *Henry Holt and Co., 383 Madison Ave., New York 17, N. Y.)* The author, a San Francisco lawyer whom *Life* called "King of Torts," has written the story of personal injury law, damage suit law, or as lawyers call it, tort law.

Surgery in World War II: Orthopedic Surgery in the European Theater of Operations, Vol. I, Editor-in-Chief, Colonel J. B. Coates, Jr., M. C. ($4.00, *Office of the Surgeon General, Department of the Army, Washington 25, D. C.)* As the late Elliott C. Culler wrote of these data, "This volume contains material which will be of value and interest not only to the military surgeon but to those interested in bone and joint surgery in civil life."

Surgery in World War II: General Surgery Volume II, Editor-in-Chief, Colonel J. B. Coates, Jr., M. D. ($4.00. *Office of the Surgeon General, Department of the Army, Washington 25, D. C.)* The 3,154 abdominal injuries upon which this study is chiefly based were the results of the violence of war and all but about 100 were combat injuries.

Handbook of Differential Diagnosis, by Harold Thomas Hyman, M. D. ($8.00, second edition, *J. B. Lippincott, Philadelphia 5, Pa.)* This edition contains 3,200 separate entries on symptoms, signs, laboratory findings as well as cross references to more than 1,200 analyses on differential diagnosis.

Current Therapy: 1957, edited by Howard F. Conn, M. D. ($11.00, *W. B. Saunders Company, Philadelphia 5, Pa.)* A whole new staff of authorities present their methods of treating the various diseases encountered by the practicing physician. The technique of using a different authority each year to bring the treatment of each disease up to date has much to recommend it over those of the usual annuals.

You Can Stop Worrying, by Samuel W. Gutwirth. ($3.00, *Henry Regnery Company, Chicago 4, Ill.)* This is a further application of the science of relaxation as assembled by Dr. Edward Jacobson of University of Chicago by one of his students. It is believed that it is impossible to worry if one is relaxed. So if one knows how to relax then one's worries are over.

Handbook of Chest Surgery for Nurses, by J. Leigh Collis, M. D., and L. E. Mabbitt. ($3.75, 4th edition, *Williams and Wilkins, Baltimore 2, Maryland.)* Operations for inflammatory conditions such as bronchiectasis and empyema do not appear on O. P. schedules as frequently as they did a short time ago, thanks to the improvement in antibiotics. Cardiac and esophageal surgery has continued to advance. Hence this new edition.

Third National Cancer Conference: 1956, ($9.00, *J. B. Lippincott Co., Philadelphia 5, Pa.)* This conference held in Detroit, covers the whole field of clinical malignancies and therefore is a volume of invaluable reference. It consists of some 70 pages of General Lectures and nearly 900 pages of symposia and panels on each of the various organs.

Symposium on the Role of Some of the Newer Vitamins in Human Metabolism and Nutrition, ($2.50. Published by *National Vitamin Foundation, Inc. New York 22, N. Y.)* This is number 12 in the Nutrition Symposium series. It is the Proceedings of the Nutrition Symposium held at Vanderbilt University, Nashville, Tenn.

Essentials of Histology, by Margaret M. Hoskins, Ph. D., and Gerrit Bevelander, Ph. D. ($4.00. Third edition. *C. V. Mosby Co., St. Louis 3, Mo.)* Designed for a beginners' course in the morphological characteristics of tissues and organs.

The Psychology of Human Differences, by Leona E. Tyler, ($6.00, second edition, *Appleton-Century-Crofts Co., New York 1, N. Y.)* It has been ten years since the first edition appeared. This second edition has been prepared with many improvements but with the emphasis on statistical significance.

Straight to the Heart: A Personal Account of the Thoughts and Feelings While Undergoing Heart Surgery, by George Lawton, with a special supplement by Ethel Lawton. ($5.00, *International Universities Press, New York 11, N. Y.)* This is a narrative of a personal experience with heart surgery by a competent writer and is as frank, inti-

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Experimental Methods for the Evaluation of Drugs in the Various Disease States—A Monograph. Under the editorship of Otto V. St. Whitelock. ($4.00, Annals of the New York Academy of Medicine, Vol. 64, Article 4, pages 463-732. *Academy of Sciences, New York 21, N. Y.)* The thesis of this conference was that serendipity is insufficient provider for better therapeutic agents. Greater reliance can be placed on the systematic study of experimental techniques employed in pharmacological research for selecting types of physiological activity that may have medical usefulness. It always has been your reviewer's opinion that serendipity is the basis of every fundamental discovery and that the techniques described in this conference are of great value in engineering these fundamental discoveries into useful applications in science and in medicine.

Medic Mirth: A Choice Collection of Cartoons with Selections from **Dr. It Tickles,** by Henry Felson. ($0.25, *Ace Books, 23 West 47th Street, New York 36, N. Y.)* Makes a delightful little piece to put on the waiting room table or chuckle with before going to sleep at your own bedside.

Your Child's Teeth, A Guide for Parents, by Edgar S. Bacon, D. D. S. ($2.50, *E. P. Dutton and Co., New York 10, N. Y.)* A book telling how dental supervision can prevent the need for straightening teeth and how good habits can preserve teeth. Has the blessing of the American Dental Association.

Freud, Psychoanalysis, Catholicism, by the Rev. Peter J. R. Dempsey. ($3.00, *Henry Regnery Co., Chicago 4, Ill.)* The author is a lecturer in psychology at University College in Cork, Ireland. One of the few rational scholars who can hear both sides of the argument about Freudism, weigh each on the judicial scales of the teaching of the church and offer evaluation that joins rather than separates religion and science.

General Urology, by Donald R. Smith, M. D. ($4.50, *Lange Medical Publications, Los Altos, California.)* This is a manual in urology for the department in the University of California school of medicine. It is a comprehensive and well designed and adequately illustrated text.

Lakeside Lecture Series—Vol. I, 1956, Lectures I-V (Apply. *Lakeside Laboratories, Inc., Milwaukee 1, Wis.)* This is a series of five extremely interesting lectures by outstanding authorities. The titles are The Enzymology of the Normal and Failing Heart; Problems and Experimental Atherosclerosis; Physiological Basis of the Therapy of Gastrointestinal Disorders; Metallic Content of the Cardiovascular Structures and Related Tissues; Physiologic and Pathologic Significance; The Changing Disability Patterns in Chest Diseases.

Physiology of the Nerve Cell, by John Carew Eccles. ($5.75, *Johns Hopkins University Press, Baltimore 18, Md.)* These are the amplified Herker lectures given at Hopkins in the fall of 1955 by the professor of Physiology in the Australian National University of Canberra, and bring us quite up to date with the biochemistry of the living nerve cell which is by far the most interesting of all the cells in the body.

Congenital Anomalies of the Viscera: Their Embryological Basis, by J. L. Bremer, M. D. ($5.00, *Harvard University Press, Cambridge 38, Massachusetts.)* This authoritative, well illustrated work presents a great variety of clinically important prenatal and neonatal anomalies from the embryological point of view. It is the first adequate account of this subject as a whole and will be welcomed by pediatricians, pathologists and surgeons alike.

Clinical Orthopaedics No. 8: Chronic Hereditary Diseases and Developmental Anomalies, by Anthony F. DePalma, editor, with the assistance of an editorial board. ($7.50, *J. B. Lippincott Company, Philadelphia 5, Pa.)* In addition to the subjects carried in the title there is in this issue a section on general orthopedics and a section on motorists' injuries and motorists' safety, both of which are extremely timely. This is one of a series of volumes in a symposium form produced under the auspices of the Association of Bone and Joint Surgeons.

Contemporary Rheumatology, edited by J. Goslings and H. Van Swaay. ($15.00, *Van Nostrand Co., Princeton, N. J.)* This is the proceedings of the third European Rheumatology Congress held at the Hague in 1955. It is a well illustrated record containing 170 articles by 238 leading European and American authorities on rheumatism. The wide range of subjects dealt with and the manner of their arrangement make this a comprehensive book of reference on the subject currently.

The Visual Fields: A Textbook and Atlas of Clinical Perimetry, by David O. Harrington, M. D. ($16.00, *C. V. Mosby Company, St. Louis 3, Mo.)* This is a comprehensive text by one of the leading authorities. Knowledge of the subject, thoroughness in examination and meticulous attention to detail are combined with originality. This presentation is thoroughly grounded, broadly prepared by an experienced teacher of the subject.

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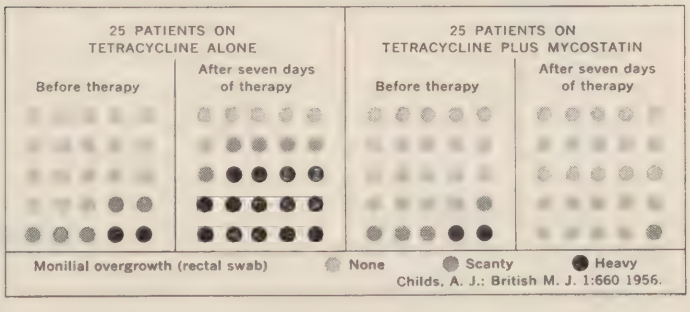
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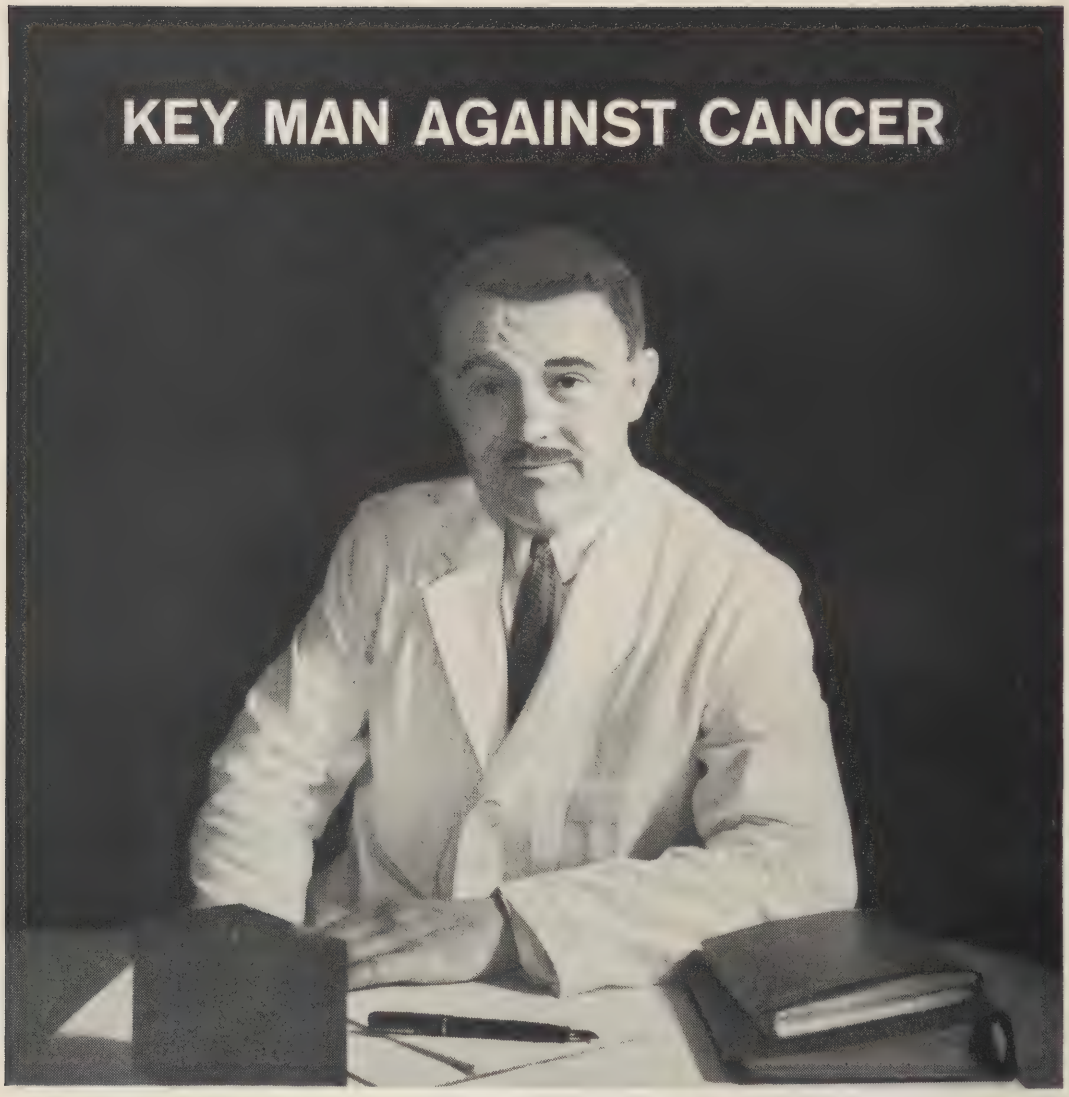
Childs, A. J.: British M. J. 1:660 1956.

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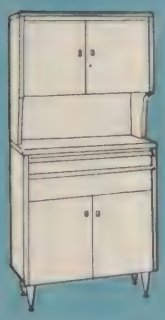
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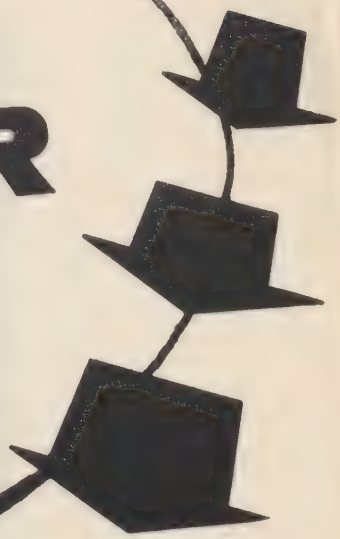
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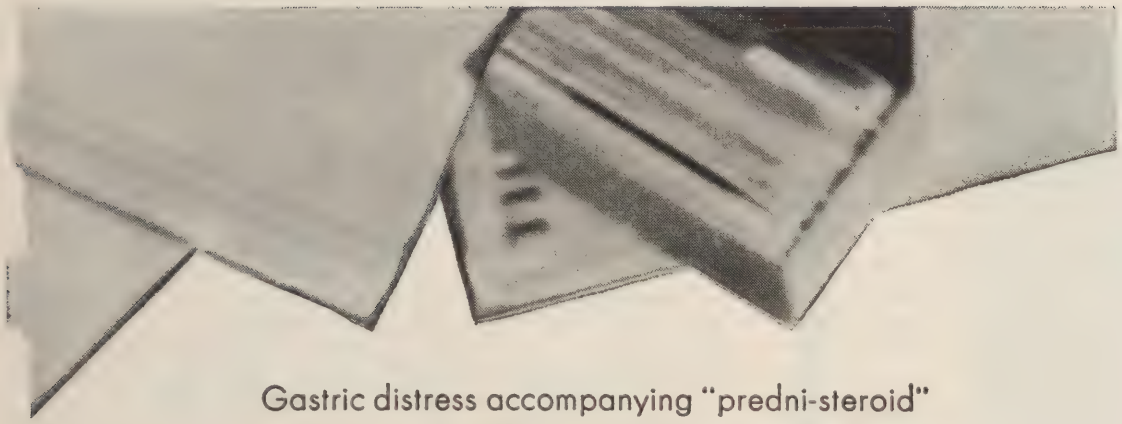
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*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:159 (June 11) 1955.

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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

BETWEEN 12,000 and 15,000 physicians will journey westward in June in search of something more valuable than gold. They'll be on a quest for the latest information on new medical techniques and discoveries at the American Medical Association's 107th Annual Meeting in San Francisco. The five days of June 23-27 will be filled with bright nuggets—including scientific exhibits, lectures, motion pictures, panel discussions, televised surgical procedures and commercial exhibits. Convenient center for the Scientific and Technical Exhibits, films, color TV and lectures will be the Civic Auditorium, the adjacent new Plaza Exhibit Hall and other surrounding buildings. Headquarters for the House of Delegates sessions will be the Sheraton-Palace Hotel.

Registration officially opens at the new Plaza Exhibit Hall Monday, June 23, at 8:30 a. m. and closes Friday noon. Advance registrations will be accepted Sunday, June 22, from 12 noon to 4:00 p. m. The Scientific and Technical Exhibits will be open to AMA physician-members *only* on Tuesday and Wednesday mornings.

Plan now to attend this worthwhile medical meeting. Watch for further details in *The Journal of The AMA.*

AMA Offers Booklet on Problems of Aging

A series of articles dealing with various health problems of the aging have been reprinted in booklet form from *The Journal of the AMA.* Four of the 11 titles in the series are:

"The Oldster and His Doctor;" "Stress and Exhaustion;" "Rehabilitation and Restorative Services," and "Preparation for Retirement Is a Must." Copies of the booklet are available on request from the AMA's Council on Medical Service.

New Name for Direct Line to MD's

One of AMA's best-known services to physicians recently changed its name. Beginning with the January 4, 1958 issue of *The Journal of the AMA* the "Queries and Minor Notes" section was carried under the title of "Questions and Answers." A check into the history of this service indicates that the first question from a physician was answered in the March 18, 1899 issue of *JAMA* under the heading of "Questions and Answers."

Each year questions relating to practical medical problems come into the *JAMA* editorial offices at the rate of approximately 2,400 a year. Each query receives a personal reply. The answers are prepared by consultants recognized as competent authorities in their respective medical fields. At the present time, about 900 authorities in all parts of the United States and Canada are maintained as consultants. If the question and its answer seem to be of interest to the majority of doctors, the material is slated for publication.

TV Jingles Plug Good Health

Well-known nursery rhyme characters like Humpty Dumpty and Jack and Jill helped to sell the idea of healthful living to many American families during 1957. Some 54 counties in 26 states sponsored the AMA's 20-second animated cartoon health spots last year, reports the Bureau of Health Education. These jingles were shown over local television stations in several metropolitan areas including Cincinnati.

Each set of spots is "personalized" with the name of the county or state medical society on both the visual and auditory film track. The series still is available to local medical societies—at no charge—by requesting order blanks from the Bureau of Health Education.

Pending Actions in AMA Organization

Recent changes authorized by the Board of Trustees include:

1. Dr. George F. Lull has assumed the new title and new position of assistant to the president, retaining the title of secretary until the June meeting of the House of Delegates.

2. The title of Dr. F. J. L. Blasingame as general manager will continue until the June meeting, when that title is expected to be discarded for "executive vice-president" by action of the House.

3. Also pending house action is the recommendation to change the title of Dr. Ernest B. Howard from assistant secretary to assistant general manager.

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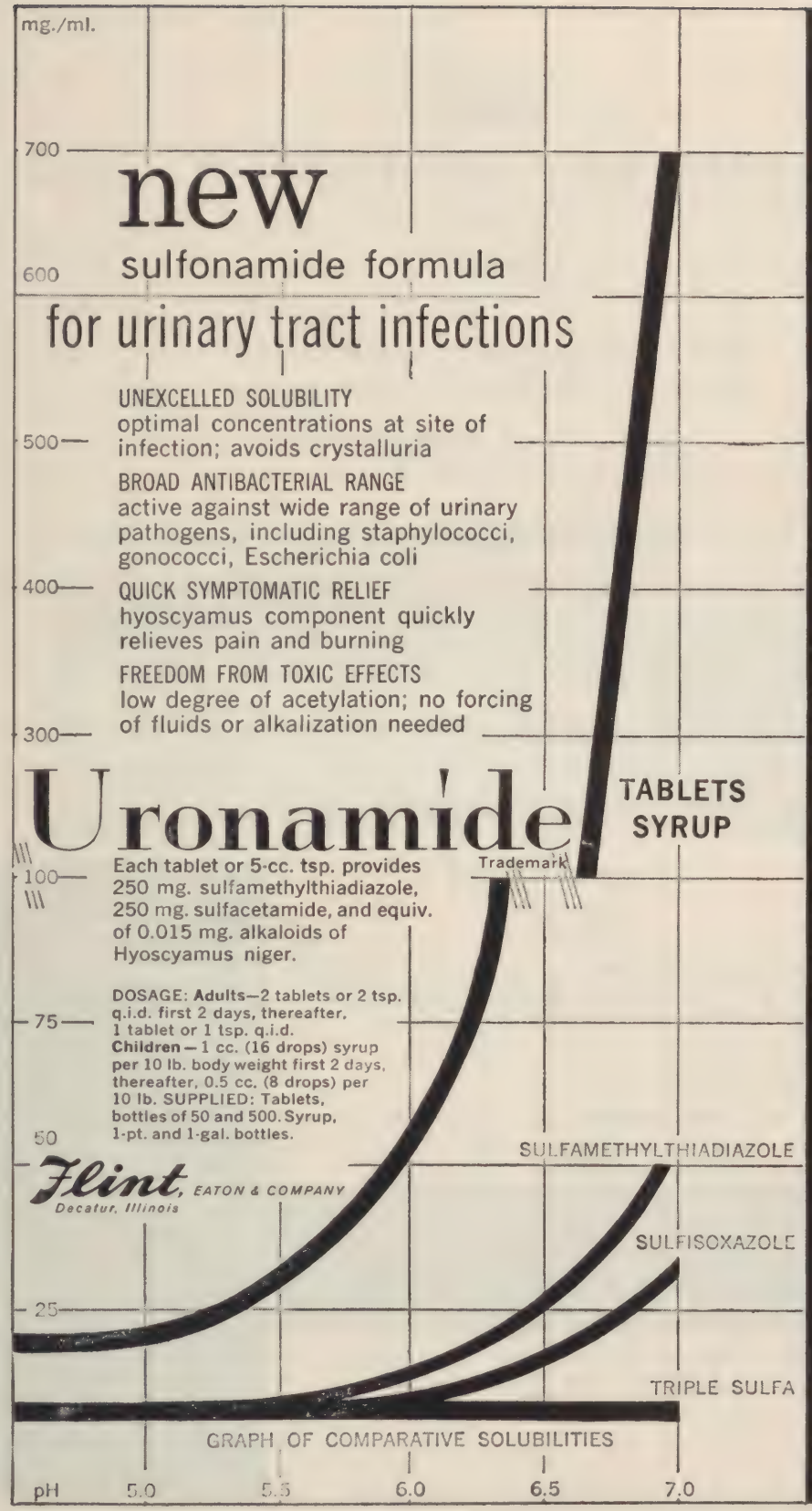
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1. Hughes, J., et al.: South. M. J. 47:1082, 1954.
2. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 48:82, 1956

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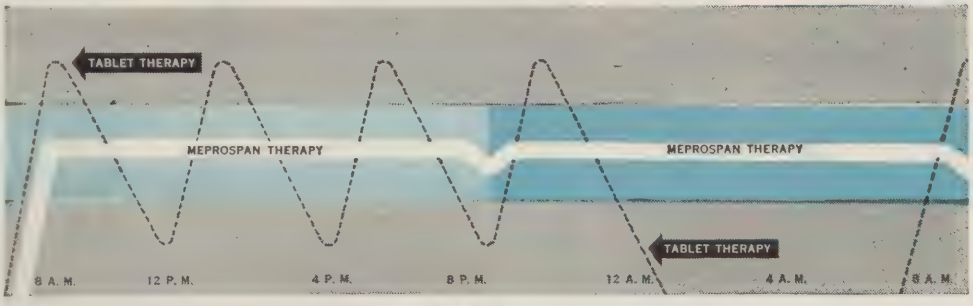
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New... meprobamate prolonged release capsules

Evenly sustain relaxation of mind and muscle 'round the clock



TWO MEPROSPAN CAPSULES IN THE MORNING RELIEVE ANXIETY, TENSION AND SKELETAL MUSCLE SPASM THROUGHOUT THE DAY.

TWO MEPROSPAN CAPSULES AT BEDTIME PROVIDE UNINTERRUPTED SLEEP THROUGHOUT THE NIGHT.

Meprospan*

MEPROBAMATE IN **PROLONGED RELEASE** CAPSULES

- maintains constant level of relaxation
- minimizes the possibility of side effects
- simplifies patient's dosage schedule

Dosage: Two Meprospan capsules q. 12 h.
Supplied: Bottles of 30 capsules.
Each capsule contains:
Meprobamate (Wallace) .....200 mg.
2-methyl-2-n-propyl-1,3-propanediol dicarbamate

Literature and samples on request.

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* TRADE-MARK CME-6598-48

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Health Resource Advisory Committee, headed by former AMA President Elmer Hess, M. D., has been assigned task of advising Office of Defense Mobilization on mobilization of health resources, their utilization and allocation under mobilization situations, and interpreting views of the nation's health community relating to mobilization of health manpower, facilities and supplies.

* * *

Armed services are producing a standardized plastic blood pack unit superior to glass from standpoint of bulk and weight, plus a newly developed blood refrigerant shipping container that is disposable and lighter than previous container.

* * *

Recent conference on nursing homes held in Washington under auspices of U. S. Public Health Service and attended by 150 representatives of nursing homes and home-for-aged organizations resolved that there is need for Federal legislation to encourage financing and reconstruction of such homes. Also, a section of the conference agreed that every elderly person in a nursing home should have a private physician; every home operator should have a physician for advice and emergency calls.

* * *

Public Health Service has contracted with Battelle Memorial Institute, Columbus, to test chemicals and antibiotic filtrates as possible agents for use against three forms of cancer in mice—leukemia, breast cancer and tumors of connective tissues; Battelle also will try to develop improved testing methods and will test toxicity of antibiotic culture infiltrates.

* * *

Defense Department and Atomic Energy Commission states that an accidental detonation of conventional nuclear explosives might possibly cause local scattering of nuclear materials in the form of dust, but this wouldn't be a fallout of fissioned material and such materials could be hazardous only if taken internally, as in breathing.

* * *

Recent report of Federal Social Security Administration shows that in 1948 voluntary health insurance paid 8.6 per cent of the nation's private medical costs, and by the end of 1956 insurance had expanded to the extent where it was meeting 26.3 per cent of those costs.

* * *

National Cancer Institute has developed a new test to measure amount of radiation exposure a person has received. Microscopic examination of hair roots is the key; greater the exposure, greater the damage to hair roots.

* * *

The veteran population of the United States was 22,724,000 as of January 31, 1938, an increase of 134,000 since the same date in 1957, a VA report shows.

* * *

Warning the nation on the food faddist and diet quack, AMA President Allman told National Food Conference in Washington that "many Americans have undiagnosed diseases of nerves, bones, blood, liver, kidneys, heart or digestive tract," and that the food faddist or diet quack often appears to the ill person as his salvation. He said that as a result, many persons put off medical attention too long.

* * *

A new synthetic drug, thiocarbanidin, will be tested against tuberculosis by the Veterans Administration, the agency announced.

* * *

New Federal Civil Defense assistant administrator for health and medical affairs is Dr. Robert L. Smith, who took the advisory post on leave of absence from his post as medical director of U. S. Public Health Service.

* * *

National Office of Vital Statistics lists downward trend in diabetes mellitus deaths, from 27 per 100,000 population in 1949 to 16 per 100,000 in 1957. Better medical management is given credit for the trend.

* * *

All 173 Veterans Administration hospitals have begun a long-term survey to provide information on cancer patients at the rate of about 25,000 per year. VA hospitals are admitting approximately 35,000 cancer patients yearly and have an average daily cancer patient load of more than 4,000.





BIFRAN®

with a plus factor in treating the overweight

In addition to dulling the appetite, elevating the mood, and easing anxiety, Bifran tablets contain the plus factor, Cholan DH® (dehydrocholic acid, Maltbie). This hydrocholeretic maintains a normal flow of bile, thus avoiding the physiological consequences of low fat intake in the usual dietary program.

Prescribe Bifran tablets for your overweight patients.

Each Bifran tablet contains 5 mg. methamphetamine hydrochloride, 200 mg. dehydrocholic acid (Maltbie), and 15 mg. pentobarbital.

Supplied: Bottles of 100, 500, 1,000.

Maltbie MALTBIE LABORATORIES DIVISION • WALLACE & TIERNAN INC. • Belleville 9, N. J.

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'DIURIL'

(CHLOROTHIAZIDE)

in

EDEMA



Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

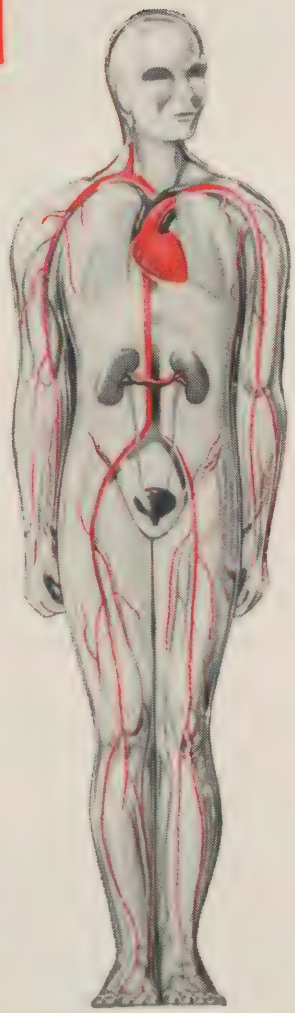
'DIURIL' and 'INVERSINE' are trade-marks of Merck & Co., Inc.

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as 1-2-3
in

HYPERTENSION



1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'



there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. . . assured anti-inflammatory effect of low-dosage corticosteroid[1]

. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

. . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more manageable corticosteroid dosage

. . . much less likelihood of treatment-interrupting side effects[1-6]

. . . simple, flexible dosage schedule



in any case
it calls for

Sigmagen®

corticoid-salicylate compound

tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

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Schering

You and Your Public . . .

Survey of Grievance Cases Indicates Understanding Is Keynote Of Individual Physician-Patient Relationship

THE keynote of the physician's relationship with his patients is "Understanding." This is a very personal type of public relations. The value of understanding is brought out in recent reports of the Cincinnati Academy of Medicine and the Philadelphia County (Pa.) Medical Society.

The fact that understanding prevents grievances is shown in the report of the Philadelphia Medical Society Professional Relations Committee. It indicates that in 26 complaints against physicians, 60 per cent probably could have been avoided if complainants had understood more about their various cases.

Difficulties Avoided

The report stated, "Undoubtedly the most important lesson to be learned from a study of this information is that difficulties most common between patients and physicians can often be avoided. Actually, of 28 cases, * * * 22 were referred because of a disagreement over the physician's fee. In 14 (60 per cent) of the latter the difficulty need not have arisen if the medical man had been sure that the patient or his family knew the approximate fee that would be involved.

"We are obligated to inform our patients about our charges unless, of course, there is an emergency. Even if this is the case we should waste no time in discussing the financial obligation at least with some responsible person in the family. Too often we are so intense about the medical problem involved that we neglect this very important aspect of medical practice and so unpleasant situations arise."

The Cincinnati Outlook

Pertinent aspects of how the grievance of a patient, real or imagined, involves the physician and his public are effectively pointed out in a *Cincinnati Journal of Medicine* article. The author of the article, Edward F. Willenborg, executive secretary of the Cincinnati Academy of Medicine, states:

"The Judicial Committee functions on the theory that a patient should have some method of obtaining a fair deal from the physician. This rule works both ways and it is the duty of the Judicial Committee to give the patient and the physician fair consideration. Usually, the final recommendation of the Judicial Committee to the physician results in an agreement between the parties and the closing of the case.

Some Feel Abused

"However, in some instances, the physician feels abused when he has received a letter of inquiry concerning certain practices that are in effect in his office. He feels that whatever he says or does is his concern and that he has the right to deal with the patient in any manner that he sees fit. If this theory is followed by even a few members of the profession, it brings about reproach from the public and, as a result, the public relations of organized medicine as a whole suffer considerably.

"The individual physician should remember that his decisions do not affect him alone. In Hamilton County there are approximately 1,100 physicians who want to belong to a profession that is highly regarded by the public and whose practices are not brought into scrutiny by the government, civic, or social organizations. It is their primary purpose to practice medicine for the benefit of patients, and they are entitled to a reasonable remuneration for administering to the sick. They usually have no difficulty with patients."

Pointing out that the physician needs help when a grievance gets beyond his office, Mr. Willenborg adds, "If no help is obtained, many of the complaints that are not resolved by an unbiased person or committee will reverberate against the physician and the medical profession as a whole."

Prevention Is Positive

The most positive approach to the grievance question is, of course, prevention of the grievance itself. Mutual understanding between the physician and his patient—or the patient's family—is the key to prevention of grievances.

Once the grievance develops, it is incumbent upon the physician to cooperate with the unit within his medical society that functions as a grievance committee. This committee functions, among other things, in the role of mediator, thus enabling the persons involved to present statements that are to be judged on an unbiased plane.

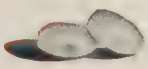
The fact that medical societies have seen fit to establish grievance procedures is evidence that the profession is actively concerned with the interests and well-being of the patient.



No Tolerance Development
Lower Incidence of Depression

Rauwiloid®

ALSEROXYLON, 2 MG.



just two tablets at bedtime

After full effect one tablet suffices

For gratifying Rauwolfia response virtually free from side actions

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When more potent drugs are needed, prescribe

Rauwiloid® + Veriloid®
alseroxylon 1 mg. and alkavervir 3 mg.
for moderate to severe hypertension.
Initial dose 1 tablet t.i.d., p.c.

Rauwiloid® + Hexamethonium
alseroxylon 1 mg. and hexamethonium chloride dihydrate 250 mg.
in severe, otherwise intractable hypertension.
Initial dose ½ tablet q.i.d.

Both combinations in convenient single-tablet form.

in each of these indications for a tranquilizer...



SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.



Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.



Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.



Senile anxiety and persecution complex dogged Mrs. K. until her doctor prescribed ATARAX Syrup. (+) It tastes good, and it's a perfect vehicle for Mrs. K's tonic.

Dosage: Children, 1-2 *10 mg.* tablets or 1-2 tsp. Syrup t.i.d. Adults, one *25 mg.* tablet or 1 tbsp. Syrup q.i.d.

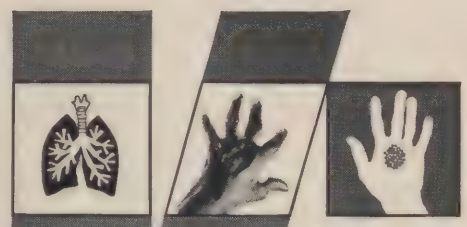
Supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

...ATARAX® gives you an extra benefit

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Division, Chas. Pfizer & Co., Inc.

A NEW, CORTICOSTEROID MOLECULE WITH GREATER ANTIALLERGIC, ANTIRHEUMATIC AND ANTI-INFLAMMATORY ACTIVITY



for your patients with

- BRONCHIAL ASTHMA, ALLERGIC DISORDERS
- ARTHRITIC DISORDERS
- DERMATOSES

Squibb Triamcinolone

KENACORT

- far less gastrointestinal distress
- safe to use in asthma with associated cardiac disease; no sodium and water retention
- does not produce secondary hypertension—low salt diet not necessary
- no unnatural psychic stimulation
- often works when other glucocorticoids have failed
- and on a lower daily dosage range

SQUIBB

Initial dosage: 8 to 20 mg. daily. After 2 to 7 days gradually reduce to maintenance levels.
See package insert for specific dosages and precautions.
1 mg. tablets, bottles of 50 and 500.
4 mg. tablets, bottles of 30 and 100.

CENTENNIAL 1858 1958 SQUIBB

Squibb Quality—the Priceless Ingredient

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

MAY 6 IMPORTANT DAY FOR ALL GOOD CITIZENS

Every Ohio doctor should have a special appointment on Tuesday, May 6. It should be a "must" on his calendar, no matter how busy his professional schedule is on that particular day. May 6 is the date for the primary elections throughout the state. The polls are open from 6:30 a. m. to 6:30 p. m.

Each eligible voter has the right on that day not only to express his preference for the most qualified nominees of the political party of his choice, he may have an opportunity also to vote on important local issues, such as bond issues and tax levies.

Unfortunately, many voters stay away from the polls on primary election days. Physicians are too good citizens to allow themselves to be classed as slackers. Prove that you and the other voting members of your family are in the "solid citizen" class by going to the polls on May 6.

If you are in a registration area—and haven't registered; or haven't voted in a special, general or primary election in the last two calendar years; or have changed your name or place of residence, better check with your County Board of Elections so that you can be placed on the list of qualified voters.

The date is Tuesday, May 6. The polls are open from 6:30 a. m. to 6:30 p. m. Somewhere in that 12-hour period, you should find time to vote, in our opinion.

THEY'VE DECIDED TO DO SOMETHING ABOUT IT

Statements and headlines criticizing the medical profession or presenting false or misleading information regarding the social-economic aspects of medicine are disturbing to physicians. They gripe about this. Unfortunately, too few make any effort to do something about it.

The Cincinnati Academy of Medicine has started a project of doing something about it. The plan of that society should be repeated in other counties by the medical societies.

Under the heading "This is Your Chance," Dr. Arthur T. Evans, chairman of the Cincinnati Academy's Speakers Bureau, writes to Academy members as follows:

" 'Doctors Charge Too Much!' 'Borrow Money Here to Pay Your Big Doctor Bills!' 'Socialized Medicine Is Good for All!' 'Alcoholism Is No Problem!' 'Why Buy Medical Insurance? They Simply Take Your Money!' 'Veterans' Hospitals Are A Wonderful Thing!'

"Do these and similar statements stimulate you to speak your mind?

"Your chance is here. The Academy of Medicine Speakers' Bureau is being reactivated. We want every doctor who would like to speak to have an opportunity to present the physician's point of view on medical problems. Big Business spends millions annually for bettering and influencing public opinion. We can accomplish this through a Speakers' Bureau of physicians who can talk informally with various groups.

"A wide range of civic organizations will be informed of this new project of the Academy. Speaking engagements will be arranged only upon consent of the physician involved. The Committee is endeavoring to obtain professional speaking help for those who desire it. Written speeches must be presented to the Committee for purposes of timing and organization of a publicity brochure. If you are interested in helping the public to understand the problems facing physicians today, please fill out and return the enclosed card immediately. We wish to encourage you to present medical problems of all types, be they clinical, economic or social."

JAYCEES SHOULD HAVE ASSIST FROM YOUNGER DOCTORS

Recent announcement by the U. S. Junior Chamber of Commerce that its 3,000 chapters are embarking on a year-around community health program presents a challenge not only to all county medical societies but to younger physicians, as well.

Program guides have been prepared for each of 10 suggested activities: Salk Vaccine Campaign; Health Fair; Better Sight and Hearing for Children; Poison Control; Assistance to Mental Health for Youth; Adventures in Living for Older People; Help for Handicapped Children; Recreation for Mental Hospital Patients; Jaycee Health Forums; Directory of Health Services.

The Jaycees in their activities in this field will need—and should have—expert guidance. None is in a better position to give this guidance than the county medical societies. In addition, the local Jaycees should have the active support of the young physicians of the area as members of the organi-

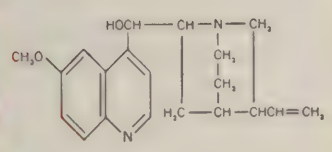
Progress in SYNTHETIC CHEMISTRY EQUALS Progress in CHEMOTHERAPEUTICS

"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

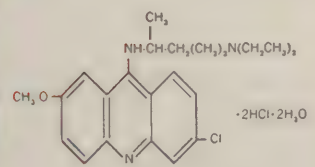
". . . Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

". . . the least toxic of its class . . ."[3]

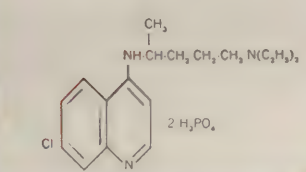
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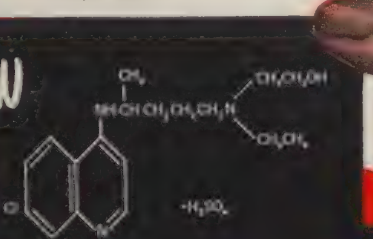
ATABRINE® DIHYDROCHLORIDE



ARALEN® PHOSPHATE



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Plaquenil® SULFATE

Remarkably effective in **RHEUMATOID ARTHRITIS**

SIDE EFFECTS MARKEDLY REDUCED

DOSE: **Initial** — 400 to 600 mg. (2 or 3 tablets) Plaquenil sulfate daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

SUPPLIED: Tablets of 200 mg., bottles of 100.

Write for Booklet

Winthrop LABORATORIES

REFERENCES:

Eichenbel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
Siebach, A.G., and Alexander, L.J.: *The Urban Physician, Bull. A. Med. Dermatologists* 5:25, Nov., 1956.
Silverstein, Theodore: *Arch. Dermat.* 73:573, June, 1956.

Atabrine (brand of quinacrine), Aralen (brand of chloroquine) and Plaquenil (brand of hydroxychloroquine) trademarks reg. U.S. Pat. Off.

zation. By becoming active Jaycees, the younger doctors will be helping that group and at the same time will be helping to keep the health programs being undertaken on an even keel.

LEGAL HAZARDS IN STERILIZATION OPERATION

Physicians who from time to time have to make a decision as to whether or not to perform a sterilization operation — for therapeutic or nontherapeutic reasons — should read carefully, if they have not done so, the article on this subject which appeared in the February 8 issue of *The Journal of the AMA*, page 645. The advice given therein is sound and timely.

Space will not permit a review of the many aspects of the subject here. However, this one paragraph from the article should be enough to warn all physicians to proceed cautiously:

"The law is still not settled, and the question of the physician's legal liability for the performance of an operation to produce sterility in the absence of therapeutic necessity is not clear. In any case, the physician before proceeding with any operation that will produce sterility should obtain from the patient or his parent and from the spouse of a married patient written consent in a form that shows the patient or parent and the spouse have consented with full knowledge of the purpose of the operation and its effects."

FEES AND THE PRINCIPLES OF MEDICAL ETHICS

Not infrequently one hears this question asked: What do the Principles of Medical Ethics say about a case where a physician doubles his fee if the patient's income is twice that of the average person?

Here's an answer given by the Judicial Council of the AMA recently:

The Principles of Medical Ethics are "standards by which a physician may determine the propriety of his conduct." They are guides to be observed, not laws to be enforced. The second sentence of section 7, providing that a physician's "fee should be commensurate with the services rendered and the patient's ability to pay" is such a guide. It is a general principle which should aid the physician in considering his fee. In addition to legal prohibitions, the very nature of medical practice prevents the rigid establishment of inflexible fees for the many services which may be rendered to any individual. This principle does not suggest, therefore, that a physician set his fee with mathematical accuracy nor does it impose on him an obligation to act contrary to conscience, reason, or experience.

In the opinion of the Council, "commensurate with the services rendered" recognizes that although there are some services which are considered invaluable, nonetheless their practical value lies within a range—within limits above or below which a fee is unconscionable. In the opinion of the Council a "patient's ability to pay" is a secondary factor, one to be considered after, not before, value "commensurate with the services rendered" is ascertained. In the further opinion of the Council it is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. The language used in this section is intended only to suggest that a physician try, in matters relating to fees, to the best of his ability to insure justice to the patient and himself and respect for his profession.

In the opinion of the Council, this section cannot properly be interpreted to mean that a physician or a group of physicians must fix average fees to be increased or reduced according to the patient's economic status, nor to imply that an arbitrary sliding scale of fees is to be adopted and applied individually or by the profession. It may not be used to justify an excessively high fee or to approve an inadequately low fee.

The Council feels this subject is important enough to add the comment that the physician can obviate many fee-complaints (and consequent ill-will) by discussing fees with his patient so that the patient may understand and appreciate the value of the service for which the fee is paid.

GUIDELINES REGARDING IMMUNIZATIONS

Recently while discussing the subject of immunizations, the Trumbull County Medical Society adopted some guidelines for the future. Among them were the following which are sensible and workable; could be examples of what may be done in many other counties:

When advance information concerning a newly developed vaccine is released to the public, there should be a meeting of the committee of the medical society with local representatives of major drug houses to discuss distribution and priorities if indicated.

When a new problem involving the question of "mass immunization" arises, there should be a meeting of a committee of the local medical society with members of the Trumbull County Manufacturer's Association and the Warren Chamber of Commerce in order to agree upon a public information program and immunization procedure.



Provides therapeutic quantities of all known hematinic factors

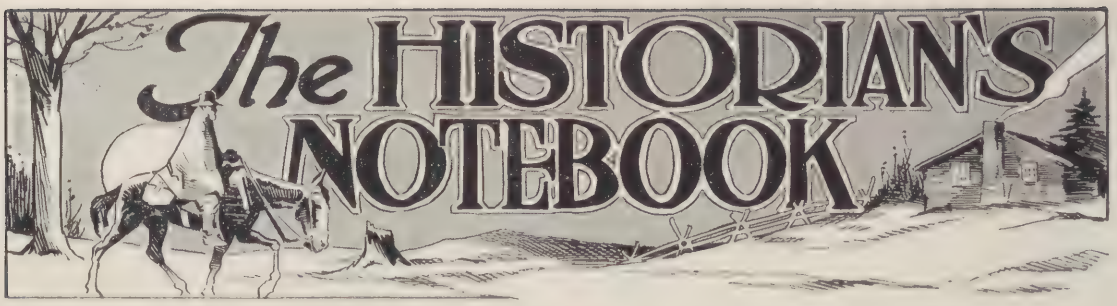
Potent 'Trinsicon' offers complete and convenient anemia therapy plus maximum absorption and tolerance. Just two Pulvules 'Trinsicon' daily produce a standard response in the average uncomplicated case of pernicious anemia (and related megaloblastic anemias) and provide at least an average dose of iron for hypochromic anemias, including nutritional deficiency types. The intrinsic factor in the 'Trinsicon' formula enhances (never inhibits) vitamin B_{12} absorption.

Available in bottles of 60 and 500.

*'Trinsicon' (Hematinic Concentrate with Intrinsic Factor, Lilly)

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Dr. Frederick C. Waite's Correspondence With Reference to Grave Robbery*

LINDEN F. EDWARDS, Ph.D.

PART I

DR. FREDERICK C. WAITE at the time of his death was Professor Emeritus of Histology and Embryology of the School of Medicine of Western Reserve University, and a nationally recognized authority on the history of medicine, especially pioneer medical education in United States. He was a charter member of the Ohio Committee on Medical History and Archives, which was organized on May 12, 1938, and which was the antecedent organization of the present Ohio Academy of Medical History, to which Dr. Waite was elected an honorary member in 1953. Following his retirement Dr. and Mrs. Waite made their home in Dover, New Hampshire, where his death occurred on March 30, 1956, at the age of 86.

For several years prior to his death the writer enjoyed the stimulating experience of carrying on a correspondence with Dr. Waite, who always very graciously and quite generously would reply to some query bearing on an aspect of medical history. Anyone who ever enjoyed the privilege of conversing with him relative to some topic dealing with medical history can well appreciate the wealth of ready information which he commanded on this subject. He expressed himself with equal fluency in his letters, which are veritable treasures of medical history, especially on the subject of grave robbing.

While collecting material for a manuscript on the subject of Resurrection Riots in the United States, an inference was encountered to such an episode occurring at Willoughby Medical College and I wrote to Dr. Waite to inquire if he could provide me with any details of the affair or give me a reference I could consult. Within two days I received from him a two-page, single spaced, typewritten letter in which he cited several examples of dissection riots.

In reply to my query he stated, "I have no information about any riot at Willoughby. There were two disturbances over dissecting at Willoughby both in 1842. In the first, some of the students got a local nit-wit into the dissecting room and told him they were going to dissect him. In trying to place him on a table he wrenched away from the students and ran and jumped through a closed window landing on the frozen ground 20 feet below with two broken legs and numerous cuts about the head by the glass. The second was when the body of a fairly prominent man was resurrected and found at the college. The records of the trustees (now at Western Reserve Historical Society) allude to recent 'disturbances' but give no details."

I had mentioned that I had searched through several northern Ohio newspapers published during the 1840's for some reference to the riot and in reply to my statement he said "The fact that newspapers give nothing definite is not

*A paper read at the Fifth annual meeting of the Ohio Academy of Medical History, Cleveland, Ohio, April 26, 27, 1957.

The Author

● **Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.**

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References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

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good negative evidence because in all parts of the country editors recognized the necessity of dissection in medical teaching and soft pedaled any references to grave robbing. This also applied to judges when students were arrested for grave robbing. Convictions were few and when convicted a nominal fine of $5.00 was imposed. I have, however, one instance where a heavy fine was imposed and another where two young men were sentenced to the penitentiary."

He enclosed a reprint of one of his papers which described a grave robbing episode at Ipswich, Massachusetts, in 1818, and in his letter he commented that the occurrence could hardly be called a riot, but had several interesting features, including the fact that the empty coffins stood on end in the cemetery during several weeks and the trial of the accused doctor resulted in the largest fine he had ever read about for grave robbing.

The Cleveland Dissection Riot

Two days following the receipt of this letter I received another one from Dr. Waite, four pages of afterthoughts, as it were, including a detailed account of a dissection riot in 1852 at the Cleveland Homeopathic College which was located at the southeast corner of Ontario and Prospect Streets, the present location of Richmond Brothers clothing store. This is illustrative of Dr. Waite's generous and kind cooperation. As he stated in a footnote "I see from the program of the Ohio Academy of Science that you are going to give a paper on this subject at Granville on the 22nd. Since your time is short, I have copied Beckwith's description of the Cleveland mob of 1852 and inclose it."

He cited several references for me to consult concerning this episode and added "What is not mentioned is that the authorities of the Medical Department of Western Reserve College feared the mob would attack that institution. Sixty muskets and ammunition were obtained from the nearby arsenal and Dr. John Delamater, the dean, then 65 years of age, stood on the front steps with musket in hand and his white hair blowing in the wind with his armed students behind him ready to repel effectively any attack by the mob. This medical college was about a half mile from the homeopathic college but only one block from the home of Professor Williams which was threatened and had the mob attacked the Williams house they would probably have gone on to the other medical college.

"I have wished I had the artistic ability to draw a picture of Delamater on the porch of the medical college with white hair and musket. Several of these students had been in the Mexican war and had the mob attacked there would have been more action than reading the riot act. I talked to one of our graduates many years ago who was one of the armed students backing up Dr. Delamater. He said some of the students hoped the mob would attack so that they could renew their practice with powder and ball and bayonet."

In his former letter he had stated that Norwood refers to a riot at Pittsfield, Massachusetts, in 1820. In his second letter he said that he had tried to verify Norwood's statement which he thought was exaggerated and should not be listed as a riot. He then gave his own interpretation of the affair according to his knowledge of it. It concerned the discovery that the body of George Butler, Jr., a respectable young man with numerous relatives had been stolen from its grave.

"Young Butler died in November 1819, and during the ensuing winter his mother constantly dreamed that his grave was empty . . . . When one of her surviving sons early in May opened his brother's grave he found that the body had been removed . . . . Almost every person in Pittsfield, men, women and children, as well as many neighboring towns went to gaze, shuddering, into the gaping grave, which was purposely left open all summer exposing its shattered and tenantless coffin to remind the spectators of the most shocking circumstances of its desecration."

Dr. Waite pointed out that this was only two years after the coffins in the Ipswich cemetery were stood on end, a circumstance that must have been known in Pittsfield, and, moreover, it was not a resurrection in connection with a medical college because it took place two years before the founding of the Pittsfield Medical College and the nearest medical school at that time was 150 miles away.

(To Be Concluded in May Issue)

Dermatological Society Is Named for Noah Worcester, Author of Textbook

The Noah Worcester Dermatological Society, a new organization formed by the Department of Dermatology of the University of Cincinnati College of Medicine, (See page 376, March issue of *The Journal*), has been named for the author of the first American textbook of Dermatology, *A Synopsis of the Symptoms and Treatment of the more Common and Important Diseases of the Skin.* Dr. Worcester occupied the chair of Physical Diagnosis at the Medical College of Ohio in Cincinnati and later filled the Chair of Pathology, Physical Diagnosis and Diseases of the Skin at the Cleveland Medical School. His textbook was printed in Cincinnati in 1850.

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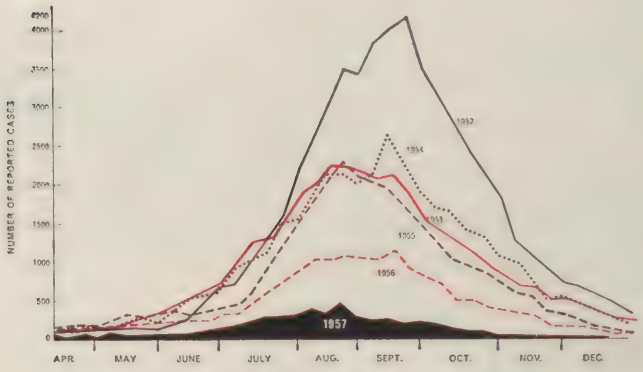
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1. *J. A. M. A.*, 165:21 (*November 23*), *1957.*
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*



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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 54 April, 1958 No. 4

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Management of Peripheral Arterial Embolism

RAYMOND J. KRAUSE, M. D., and JOHN J. CRANLEY, M. D.

PERIPHERAL arterial embolism is a prime example of a "medico-surgical" emergency, in that proper treatment demands full use of both medical and surgical therapeutic measures. The fact that nine unsuccessful attempts were made to remove an arterial embolus surgically before Labey [1] succeeded in 1910 attests to the compelling logic of the surgical removal of arterial emboli. In the next 30 years, many successful embolectomies were performed; nevertheless, the surgical treatment of arterial embolism remained little more than a delaying tactic until anticoagulant therapy became fully available, providing both definitive and prophylactic management through the use of a combination of methods.

In addition to its usefulness in the prevention of recurrent embolism, anticoagulant therapy (heparin) is of inestimable value in preventing or delaying propagation of the clot distally following lodgement of the embolus. Distal propagation of the clot and the formation of new soft clot in the suddenly quieted arterial bed is believed to be the most important factor determining survival of the patient or the extremity after embolization. Immediate removal of the embolus prior to the occurrence of secondary thrombosis is, of course, ideal; but in practice this ideal is seldom attained. If the operation cannot be performed within four hours after the patient is seen initially, heparin 50 mg. intramuscularly or intravenously will greatly fortify the chances of successful surgical treatment.

Twenty-five patients having 30 peripheral arterial emboli were treated between August 1952 and October 1956. Eighteen emboli occurring in 15 patients were removed surgically; five embolisms were treated with anticoagulant agents without surgery; and in 7 instances, no specific treatment was given.

In 29 instances, the site of lodgement of the embolus could be determined precisely: (Table 1).

TABLE 1.—*Site of Lodgement*

Artery	No. Extremities	Per Cent
Femoral	14	49
Iliac	7	24
Popliteal	4	14
Brachial	2	7
Ulnar	1	3
Aorta	1	3
Total	29	100

Analysis of larger series [2,3,4,5,6] reveals that approximately 80 per cent of peripheral arterial emboli that affect an extremity lodge in the aorta, iliac, femoral or popliteal arteries. The significance of this high indidence can be fully appreciated when it is realized that death, amputation or severe incapacitation are to be expected following

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lodgement of an embolism in these arteries if untreated, whereas such complications are less likely to occur following occlusion of an artery in the upper extremity or below the knee.

Origin of the Embolus

The heart was the site of origin of the embolus in 24 of the 25 patients in our series. In one instance, the presumed site of origin was an abdominal aortic aneurysm. Of the 24 patients with known heart disease, 20 had auricular fibrillation; three were recovering from a recent myocardial infarction; and one had severe cardiac decompensation.

Time Interval Preceding Embolectomy

In 1923, after analyzing his own 11 embolectomies plus 51 cases from the world literature, Key[3] noted that none had been done successfully more than 24 hours after lodgement of the embolus. He further concluded that the prognosis of embolectomy was quite favorable during the first 10 hours but that after this period, it rapidly became less favorable. He added the comment, however, that "no set time before gangrene occurs can be given: one must be prepared for great individual differences."

Several authors reporting series of embolectomies[2,3,5,7] have noted an occassional successful outcome many hours after lodgement of the embolus. For example, Warren and Linton[2] reported one with good result 60 hours after embolization. Recently, this aspect of the problem has been reemphasized by Shaw[8] and Crawford,[9] who reported removing not only the embolus but the large distal propagating clot from arteries long after the commonly accepted period of surgical operability.

Our experience has been similar to theirs. One artery was cleared as late as 48 hours after lodgement of the embolus (cf. table 2). Therefore, it seems clear that no patient should be denied an opportunity for surgical treatment on the basis of elapsed time alone. As long as there is no obvious gangrene of the skin, profound rigor mortis of the muscles, or muscle necrosis as evidenced by swelling and induration over the muscle bellies, embolectomy should be attempted.

TABLE 2.—*Results of Embolectomy*

Elapsed Time in Hours	No. Extremities	Success	Failure	Death
6 or less	5	4	0	1
6 to 12	5	2	1	2
12 to 24	5	1	1	3
30	1	1	0	0
36	1	0	1	0
48	1	1	0	0
Total	18	9	3	6

TABLE 3.—*Correlation of Site of Embolus and Result of Embolectomy*

Site of Embolus	No. Extremities	Success	Failure	Death
Femoral artery	12	6	2	4
Iliac "	3	2	0	1
Popliteal "	2	1	0	1
Brachial "	1	0	1	0
Total	18	9	3	6

Technique of Embolectomy

Spinal anesthesia was used in most of the 15 operative patients. When the embolus lies in the aorta or iliac artery, it is exposed by a retroperitoneal or low abdominal incision. The femoral and popliteal arteries are exposed by longitudinal incision. The incision is made large enough for the operative technique to be performed with ease. Proximal and distal control of the artery must be obtained before it is opened. This not only controls hemorrhage, but the distal occluding clamp prevents fragments of the clot from breaking off and embolizing secondarily to the distal arterial tree. The arteriotomy incision is usually made just below the embolus or over its most prominent portion. In this way, the arterial pressure from above will usually expel the clot, so that manipulation is unnecessary.

Clots in the distal segments of the artery are removed by a gentle milking pressure with the finger. If this does not suffice, the artery is opened lower down in the limb and flushed out in a retrograde manner with saline solution. In one instance, a cast of the entire superficial femoral artery from the popliteal space to the groin was flushed out in one piece, in this way.

A weak solution of heparin is used locally to prevent thrombosis and eliminate the air in the artery before closure. A solution of 10 to 15 mgm. of heparin in 100 cc. of saline has been found to be effective. Meticulous hemostasis is obtained before closure and the patient is then started on aqueous heparin 50 mgm. every four hours. If the patient has received 25 to 30 mgm. of heparin during the procedure, then the first dose is given four hours after closure. Oral anticoagulant therapy is started the following day and when the prothrombin time is less than 20 per cent of normal, the heparin is discontinued.

Conservative Treatment

As pointed out by Key in 1923,[3] the most important factor in determining the survival of the limb following lodgement of the embolus is the extent of the propagation of the clot. It is most probable that the spontaneous recovery rate would be high, were it not for this factor. Therefore, heparin is the drug of choice if the patient is to be treated medically.

Lumbar sympathetic blocks have not been used

in any of our patients and are believed to be contraindicated, first because of the danger of hemorrhage if the patient is receiving anticoagulant therapy, and secondly because it is believed that if arterial spasm exists, it is of the intrinsic variety, and would not be influenced by automatic nervous system paralysis. It is true that a lumbar sympathetic block would eliminate the normal tone of the arterioles, and therefore augment the total blood flow to the extremity; but in the event of widespread thrombosis, this would not be a sufficient increase in blood flow to preserve the limb. And if widespread thrombosis did not occur, it would not be necessary.

Four patients were treated with heparin. One of these had a myocardial infarction as the source of the embolus and died shortly after lodgement of the embolus. In three instances, treatment was successful, in that the limb survived. In two of these, however, there is no doubt that the patient would have had severe intermittent claudication, had they been well enough to be ambulatory.

The major objection to treatment of all patients with heparin is not that it would not be successful in a certain number of cases, but because of the difficulty in predicting the cases in which it would prevent ischemic necrosis of the limb. And furthermore, the surviving limb may have very severe functional disability despite the fact that the collateral circulation is sufficient to keep it alive. Finally, anticoagulant therapy, although effective and highly useful, may at times expose the patient to a greater risk than surgical therapy.

In seven instances, no specific treatment was given. These patients were seen too late to initiate treatment. Among these, there were four deaths and three major amputations.

Summary

Peripheral arterial embolism is a prime example of a medical and surgical emergency. The basic pathology as far as the peripheral circulation is concerned is twofold: the embolus itself and the thrombosis in the arterial tree distal to the embolus. Therapy should be directed toward prevention of distal thrombosis, early removal of the embolus, and prevention of recurrent embolization. As long as the limb is not overtly gangrenous, embolectomy should be considered because recent experience has demonstrated the feasibility of clearing the arterial tree even two or three days following lodgement of a major arterial embolism.

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Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is a summary of cases presented before the Franklin County Pelvic Cancer Delay Committee on Wednesday, February 19, 1958. The meeting was held at the Columbus City Health Department.

Case No. 53. This is a 66 year old white female with carcinoma of the endometrium found in surgical specimen two years ago. Hysterectomy done because of bleeding. Bleeding recurred two weeks ago. Pelvic examination two weeks ago revealed carcinoma growing down the upper one third of the vagina. Diagnosis is recurrent endometrial carcinoma in vaginal vault. Patient has irradiated carcinoma.

Comments: Physician delay 48 months. Preliminary dilatation and curettage should be done prior to surgery if endometrial carcinoma is to be detected.

Case No. 54. Patient is a 52 year old white female. She is a cancerphobiac and has been having periodic pelvic examinations with papanicolaou smears every six months. Three months ago pelvis reported normal, negative. Three weeks ago patient developed lower abdominal discomfort. Diagnosis of uterine fibroids made. Has had increasing pelvic mass from two times normal size uterus to uterus size of four months pregnancy in a period of one week. Currettments diagnosed as sarcoma. Laparotomy revealed inoperable sarcoma with total abdominal metastasis.

Comments: Physician delay, none. Patient delay, none. This represents the maximum in attempt to prevent development of far advanced cancer, but a minimum of favorable prognosis due to the tremendous malignancy of this sarcoma. It was neither the patient's nor the doctor's delay which caused this poor outlook—it's the nature of the beast.

Trauma and Cardiac Disease

The role of trauma in causing cardiac disease is limited. Most of the controversy stems from the relation of coronary disease and work. Recent pathologic studies indicate that the fate of a patient with arteriosclerotic heart disease may well depend on the demands made on the myocardium at critical times—David Roth, M. D., Patterson, N. J.: *J. M. Soc. New Jersey*, 55:10, January, 1958.

Principles of Anorectal Surgery, Re-Defined

W. H. HAMILTON, M.D., and C. H. HAMILTON, M.D.

The Authors

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● **Dr. C. H. Hamilton, Columbus, is resident in Surgery, White Cross Hospital.**

AT intervals it is well to re-evaluate surgical procedures of any kind. This is an age of rapid change and certainly medicine is no exception. However, it is our contention that certain basic principles exist in surgery that must be followed to obtain satisfactory results. In proctology, there are not only the general principles to be followed as in any field of surgery, but also specific principles peculiar to the anorectal tract which need to be observed to give the best results. It is our purpose to emphasize the principles which have proved successful over many years.

There is a continuing need to stress the guiding principles in any field of medical endeavor. A distressing number of patients referred to our office have persistent symptoms despite one or more previous rectal operations. We feel these poor results are based upon inadequate knowledge of the anorectal anatomy and pathophysiology or inability to apply the knowledge effectively.

We hope this paper will be of some aid to those who deal with anorectal surgery. The principles are six in number and will be presented separately.

I. Thorough Diagnosis

A complete knowledge of the normal anatomy of the anorectal tract must exist in the mind of the physician. Only in this way can pathologic states be recognized and subsequently treated effectively. Our British colleagues have been responsible for describing the practical applied anatomy of the anal canal. Milligan and Morgan's initial article[5] is probably the most widely known and frequently referred to. Recently another group[4] from St. Marks Hospital has brought out some interesting points which vary from Milligan and Morgan's classical paper.

All patients with bowel or rectal complaints should have a digital examination, an anoscopic examination and sigmoidoscopic visualization of the upper ampulla and rectosigmoid junction. Certain selected cases and all cases over 40 require barium enema x-ray studies. End results of treatment depend on a complete knowledge of existing pathology.

We should like to emphasize the importance of a gentle approach to examination of these patients. Attempts by the physician to perform a painless examination are greatly appreciated by these people who frequently have suffered for long periods before consulting a doctor. It is important to point out that the thoroughness of an examination should never be compromised. If the patient is too tender to examine at the initial visit, the physician should place him on local conservative measures and analgesics and carry out an adequate examination at a later date. Attention to the patient's comfort in the management of these cases from the initial visit, to the last postoperative checkup is one of the biggest assets in any practice, for these people practically never forget this considerate approach and are prone to comment upon this to other patients.

In cases which require surgery, a discreet choice of operative time is imperative. Just as in cholecystitis or diverticulitis, inflammatory reactions should be managed conservatively before operation is attempted. Tissues are much more amenable to corrective surgery after inflammation has subsided. It should be mentioned that abscesses adjacent to the anus or rectum are difficult to localize when antibiotics are being utilized. We do not advocate antibiotic therapy except in stubborn infections following adequate surgical drainage or in frank cellulitis. Antibiotics will never replace good basic surgical principles.

A period of conservative therapy frequently will obviate surgery. Following this principle is valuable, in that excessive normal tissue is not removed during an acute stage. This is especially true in patients with hemorrhoidal prolapse with associated marked edema and congestion. Many unnecessary hemorrhoidectomies are performed due to poor choice of operative time. A good example is the female who is immediately postpartum. However, we do not recommend any delay in cases of prolapsing thrombotic necrotic hemor-

Read before the American Proctological Society Meeting in New Orleans, La., April 25, 1957.

rhoids. This situation demands immediate surgical intervention. If the findings are primarily those of a marked congestion without ulceration or necrosis, and the patient responds to rest, heat and analgesia, then surgery is best delayed for several days.

Accurate diagnosis of, and prior treatment of conditions contributing to or aggravating anorectal pathology is necessary. Perineal or pelvic relaxation, prostatic hypertrophy, and chronic pulmonary disease with cough should be treated before good results can be expected with proctologic surgery.

We have found two maxims to be of great assistance to us in our practice in evaluating patients for treatment.

First, do the patient no harm.

Second, operate only if you feel the patient can be benefited.

II-a. Conservation of Essential Tissues

The mucous membrane or lining of the anorectal tract is the most valuable tissue in the area. Once removed, it does not regenerate. It is replaced or bridged over with granulation or scar tissue. It is necessary to remove enough of this tissue in a hemorrhoidectomy to relieve symptoms, but if too much is sacrificed stricture and a tendency for ulceration and abscess formation result. It is this problem which develops when the occasional operator or the untrained physician attempts a proctologic procedure. What appears to be a simple operation on the surface becomes a problem-laden tragedy for the doctor and patient. Who suffers the most? The patient! An optimum amount of tissue must be removed to get the best result. The general rule should be—if in doubt, do not dissect further. It is far better to not remove enough tissue than it is to resect too much.

II-b. Obliteration of Diseased or Useless Tissues

Thorough obliteration of diseased areas is necessary to cure the patient completely. As we all know treatment for fistulae-in-ano is often inadequate. This appears to occur for several reasons. First, the operator may feel insecure about dissecting through muscle tissues to completely remove the tract. Second, the complexity of multiple-plane fistulae is ignored. J. E. Dunphy[3] has summarized the important points regarding diagnosis and treatment of fistula-in-ano.

We would emphasize the importance of incising a sphincter muscle ring at right angles, not obliquely. The least dangerous place to incise the sphincter is in the posterior mid-line. When it is necessary to split the muscle, the ends may be loosely sutured and re-approximated after the diseased area is removed. Thus a thin block scar forms and wide retraction of the muscle at that point is not permitted. The normal mucous membrane may then be drawn over the repaired muscle after the internal opening has been dissected out and a smooth lining obtained.

Attention to adequate drainage to the outside with healing of the tract bed from the bottom up is important. A two stage procedure should be utilized for tracts running deep to the entire muscle ring. It is generally a bad practice to pack the bed of a fistulous tract open. If any inert material is left in the area of dissection it should be removed in no more than 24 hours.

If certain of these basic principles are followed the blight of postoperative stricture and its antithesis, incontinence, will be vastly reduced.

III. Plastic Reconstruction—Including Replacement of Displaced Tissues

As was mentioned before, many of the cases which are referred to the proctologist are for complications which have occurred following other operative procedures. The majority of these cases truly need a plastic reconstruction to regain a semblance of normal anatomy and function.

The biggest problem is usually a dearth of the valuable lining substance of the low rectum and anal canal. Thus a plea is made for the judicious use of mucous membrane. Hemorrhoidal tissue should be removed in such a way that the mucous membrane may be sutured over the sphincter muscle without tension. Allowance for the contraction which occurs during healing must be made. Otherwise a functional stricture will result.

In performing a rectoplasty several pathologic states may have to be dealt with simultaneously. In removing a hemorrhoidal segment and a fistula-in-ano in the same quadrant the dissection is begun externally and carried up to the anorectal line to completely remove the diseased areas. The crypt bearing portion is removed and the rectal mucosa is brought down over the sphincter muscle to the subcutaneous fascia, thus forming a new mucocutaneous junction. The newly reconstructed line bears no crypts and therefore is less vulnerable to the development of pathologic states which are prone to occur on this basis.

Dissection should be performed in radial lines projecting out from the central point of the anus like the spokes of a wheel. This is best for two reasons. First, there is less tendency to remove excessive wedges of tissue circumferentially which would result in stricture. Second, as healing progresses the tissues are elevated back to normal position without constriction of the lumen and

without incarceration of the sphincter into inflexible bands of scar tissue.

Severe hemorrhoidal prolapse drags the sphincter muscles down with it, causing an actual ptosis. Careful dissection of the lowermost margin of the sphincter muscle from the interior of the pile can be carried out with the thermal knife, and the mucosal margin anchored in such a way that it acts as a sling or hammock for the sphincter muscle. This replaces the muscle back to a normal position. Patients describe a new feeling of suspension by the time they receive their six weeks' postoperative checkup in the office.

IV. Effective Surgical Drainage

Attaining adequate surgical drainage is a basic principle in any field of surgery, but in proctology it assumes cardinal importance. Since the anorectal area cannot be made sterile before or after surgery, effective surgical drainage must be established in the operating room to assure a satisfactory end result in the shortest time.

Attention to good hemostasis and formation of satisfactory drainage pathways to the outside will minimize postoperative edema, will prohibit pocketing of potentially infected serum and exudate and subsequent abscess formation and thereby will reduce postoperative pain.

Perianal and ischiorectal abscesses must be incised widely and means instituted to promote drainage until the tissues return to normal softness. Poor drainage from inadequate incisions cause delay in healing and excessive scarring.

Frequent inspection of the operative site is necessary to keep drainage pathways open. It is necessary for sinuses left following fistulectomy to heal from the bottom. Bridges of granulation form rapidly between tissue margins. Granulation may be gently trimmed or cautiously cauterized with silver nitrate where necessary. Penrose drains, gauze wicks, and medicated pads will never substitute for frequent inspection by the physician.

V. Requisites in Operative Technique

Satisfactory exposure of the operative field makes the difference between success and failure in any surgical procedure. We prefer the prone modified jack-knife position as does Swinton at the Lahey Clinic. The buttocks may be easily spread with wide adhesive straps to aid exposure. The surgeon is in a relaxed position and the assistant does not tire so easily. Exposure must not only be gained, but maintained else the end result of the operation is compromised.

Regional anesthesia is the type best suited to most proctologic procedures. Either caudal or low spinal is acceptable. Adriani[1] has recently given an excellent summary of the many advantages of regional anesthesia and the agents available for use. The surgeon should always be attentive to the possibilities of hypotension caused either by dropping the patient's lower extremities down during regional anesthesia or by local anesthetic reactions. It is preferable if a needle is always kept in a vain ready for emergency administration of a vasopressor should the situation arise. Our anesthesia staff has been alert and well aware of the necessity for maintaining a good airway with the patient in the prone position.

We would emphasize the need for minimal tissue trauma. Frequently in the anorectal inflammatory conditions, tissues are extremely friable and must be handled with great care. Generally speaking small atraumatic clamps should be used. There is no need for large crushing instruments. Atraumatic chromic catgut may be put to excellent use in anorectal surgery. This does away with large shanked needles which tear tissues while penetrating them. Moistened sponges are less traumatic than dry ones.

We have used the thermal knife with a great deal of success. This provides a relatively bloodless field, thereby improving visualization of structures. It is much less traumatic than the electro-cautery which may devitalize deeper tissues without the operator being aware of it.

We mention the long acting oil anesthetics only to condemn them. These agents are meant to give relief from postoperative discomfort for the period of convalescence. However, they frequently remove all sensation permanently. As Adriani[1] and others have pointed out, these local anesthetics are necrotizing and neurolytic. Reports of severe postoperative abscesses and sloughs have made it necessary for many surgeons to discontinue use of the drugs. We have found lidocaine (Xylocaine®) to be of considerable value for local infiltration. It has excellent spreading action and is not destructive to tissue.

Finally, we feel it is unwise to plug the anus with a large calibre pack at the end of a rectoplasty. This merely causes the patient unnecessary discomfort from sphincter dilatation and does little to add to the hemostasis. A small Penrose drain or vaseline gauze wick left in the anal canal will permit drainage of mucus and passage of some gas without adding to the patient's difficulties. A pressure dressing applied to the operative site from below with wide adhesive strapping lifts the anorectal area and promotes hemostasis. This is removed in 12 hours.

VI. Postoperative Care

The key to a successful, uncomplicated postoperative course is frequent, regular inspection. The surgeon can in this way recognize incipient

difficulties early and prohibit extension of morbidity. Nesselrod[6] has recently pointed out the importance of this principle.

Following anorectal surgery pain is generally severe. This must be recognized and measures taken to minimize the discomfort. Patients are highly appreciative of the physician's efforts to relieve pain. We feel that analgesics should be utilized in liberal quantities the first 48 to 72 hours, then gradually reduced as necessary. Morphine and Dilaudid® remain the most effective drugs for relief of pain. We have found promazine derivatives of supplementary value in certain cases where doses of narcotics must be limited or in patients with low pain threshold or severe psychoneurotic tendencies.

Swinton has emphasized the value of early application of moist heat to reduce sphincter muscle spasm. We utilize a routine which calls for frequent warm applications of mild astringents the first day following surgery, supplemented with Sitz baths the second day. Then both are continued until healing is well along. These treatments not only reduce spasm but promote drainage and cleanse the operative site without irritation.

Cantor[2] has presented experience with the oil soluble anesthetics in office proctology. We feel there are definite disadvantages to the use of these agents. Not only may they be destructive to tissue, but by rendering the operative area insensitive they may permit the patient to try things from which he would normally refrain. Too early ambulation and return to work may cause extensive bleeding, excessive edema and breakdown of a satisfactory rectoplasty. We feel the majority of patients deserve hospitalization and benefit more from an operative procedure in a well equipped and adequately staffed surgical suite than they do from an office procedure without a closely followed postoperative course.

The surgeon should suggest methods to help the patient attain normal bowel regulation without trauma following surgery. During the healing stage small doses of mild laxatives and lubricants may be used to accomplish passage of a fairly solid stool without pain. Adequate water intake is required to keep the bowel and stool hydrated. The patient can be taught to insert a glycerin suppository gently with a well lubricated finger cot and simultaneously massage and dilate the anal ring. This is preferred over the anal dilator, which is traumatic and may be intensely painful.

The surgeon should not discharge these patients from the hospital too soon. Because the patient has had one or even two bowel movements means essentially nothing. Many of these people spend miserable hours and days at home following a premature release. Their postoperative course must be followed closely and observed frequently as to progress of healing, the patient's ability to regulate his bowel action, unusual bleeding or discharge, abnormal complaints of pain and the like. As a general rule a week is the minimum time required for satisfactory convalescence. Cases with more extensive pathology must be retained longer. The art of medicine must be practiced as well as the science of medicine. Physicians who are considerate of their patient's overall welfare will be overwhelmingly rewarded for their efforts.

We have attempted to present the basic principles of proctologic surgery and show how they have contributed to a successful practice. We hope these principles will prove valuable to those who are currently dealing with or who will be treating anorectal disease.

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The Thyroid Factor in Multiple Sclerosis

In a small series of eighteen cases of multiple sclerosis, ten of whom had a thyroidectomy, degenerative changes in the thyroid were found in all ten.

A case report is given of a nurse with suggestive amyotrophic lateral sclerosis symptoms and signs, whose one brother died of multiple sclerosis at the age of 35 and another recently died at the age of 54 with amyotrophic lateral sclerosis. Two sisters and a brother, as well as a niece, had a thyroidectomy for goiter. Other cases of multiple sclerosis are cited with a duoparental goiter background and an offspring eliciting multiple sclerosis.

It is suggested that the selective action of the thyroid on ectodermal tissues would explain the loss of the ectodermal myelin sheath or neurilemma, the primary step in the pathology of multiple sclerosis.

A large series of multiple sclerosis cases is necessary to substantiate or disprove the hypothesis advanced in the article.—Robert C. Moehlig, M. D., Detroit: *J. Michigan M. Soc.*, 57:247, February, 1958.

Renal Colic Due To Necrotizing Papillitis

ARTHUR A. ROTH, M.D.

IN 1877 Von Friedreich, a pathologist, described the first case of renal papillary necrosis, proven by postmortem study, in a 70 year old man with prostatic disease and hydronephrosis. For many years thereafter this entity remained a postmortem finding. In recent years, Gunther primarily and others have shown that this condition was frequently found in persons dying of diabetes with associated urinary infection. More recently still it has been demonstrated that patients having this comparatively rare form of renal disease may not have diabetes, they may recover from it and occasionally the presenting symptom may be renal colic due to the passage of renal papillae down the ureter. This condition has been described under a variety of terms such as "Necrosis of the Renal Papillae," "Papillary Necrosis," "Necrotizing Renal Papillitis," and "Papillitis Necroticans."

Case Report

My patient, a 58 year old white female, was admitted to the hospital as a case of acute abdomen and a tentative diagnosis of acute cholecystitis. Her complaint was that of right upper abdominal and lumbar pain of four days' duration with radiation of the pain to the right thigh, nausea and vomiting. The pain was further described as being intermittent in nature. A cholecystogram showed normal gallbladder function. An intravenous pyelogram showed no visualization of the kidneys. Physical examination showed only tenderness in the right flank.

Laboratory examinations were as follows:

Urine: Slight trace of albumin; Negative for sugar; Specific Gravity, 1013; Microscopic: many white blood cells, 3 to 4 red blood cells, many epithelial cells.

Blood: Blood urea nitrogen, 34 mg. per 100 ml.; Creatinine, 2.6 mg. per 100 ml.; Serologic test for syphilis negative; hemoglobin 9.8 Gm.; hematocrit 34; white blood cell count 9,800; red blood cell count 3,890,000; Phenolsulfonphthalein test 7 per cent in 60 minutes. Glucose tolerance tests were normal.

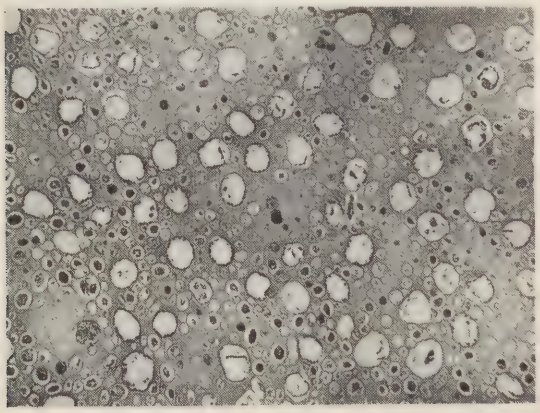


FIG. 1. One of the renal papillae recovered from urine.

Urological consultation was requested and cystoscopy was performed. Floating in the urinary bladder were three small brown fragments which at first I thought were old blood clots. Upon removing them from the bladder I found they had a spongy feel and did not disintegrate. Microscopic sections were made. (See figure 1.) Retrograde pyelograms showed anterior rotation of the left kidney and no evidence of missing papillae on the right side. No growth was obtained on culture from either kidney or the bladder. Urine culture later grew out *Staphylococcus aureus* sensitive to Chloromycetin® and other antibiotics.

The patient was treated with Chloromycetin and other antibiotics without clearing the infection, so all drugs were discontinued. The specific gravity of the urine varied from 1007 to 1020. She had no more urinary tract complaints and no more papillae were passed. The patient has been followed for 39 months and has had bilateral cataracts removed without untoward incident. Her lowest blood urea nitrogen has been 20.5 mg. per 100 ml.

Discussion

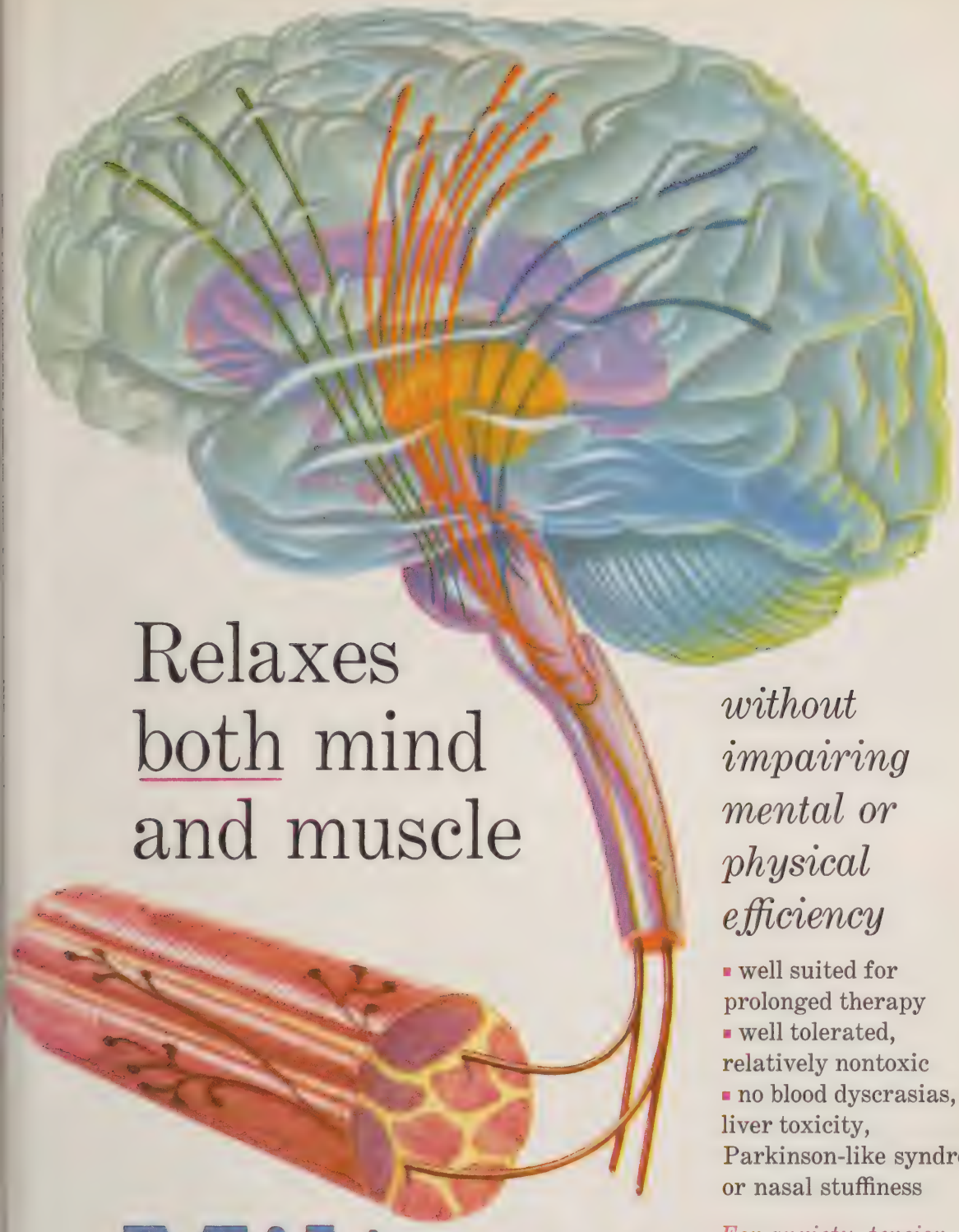
The cause of necrosis of renal papillae in this disease has never been adequately explained. Apparently infection or rather pyelonephritis plays a role in producing an ischemia at the base of the papilla, causing necrosis and sloughing of that structure. It has occurred with and without lower urinary tract obstruction and a case of unilateral renal papillitis due to ureteral obstruction by an aneurysm of the right common iliac artery was described by Cates and Hewer. Necrotizing papillitis is associated with diabetes in the greater number of recorded cases and is more prevalent in women than in men.

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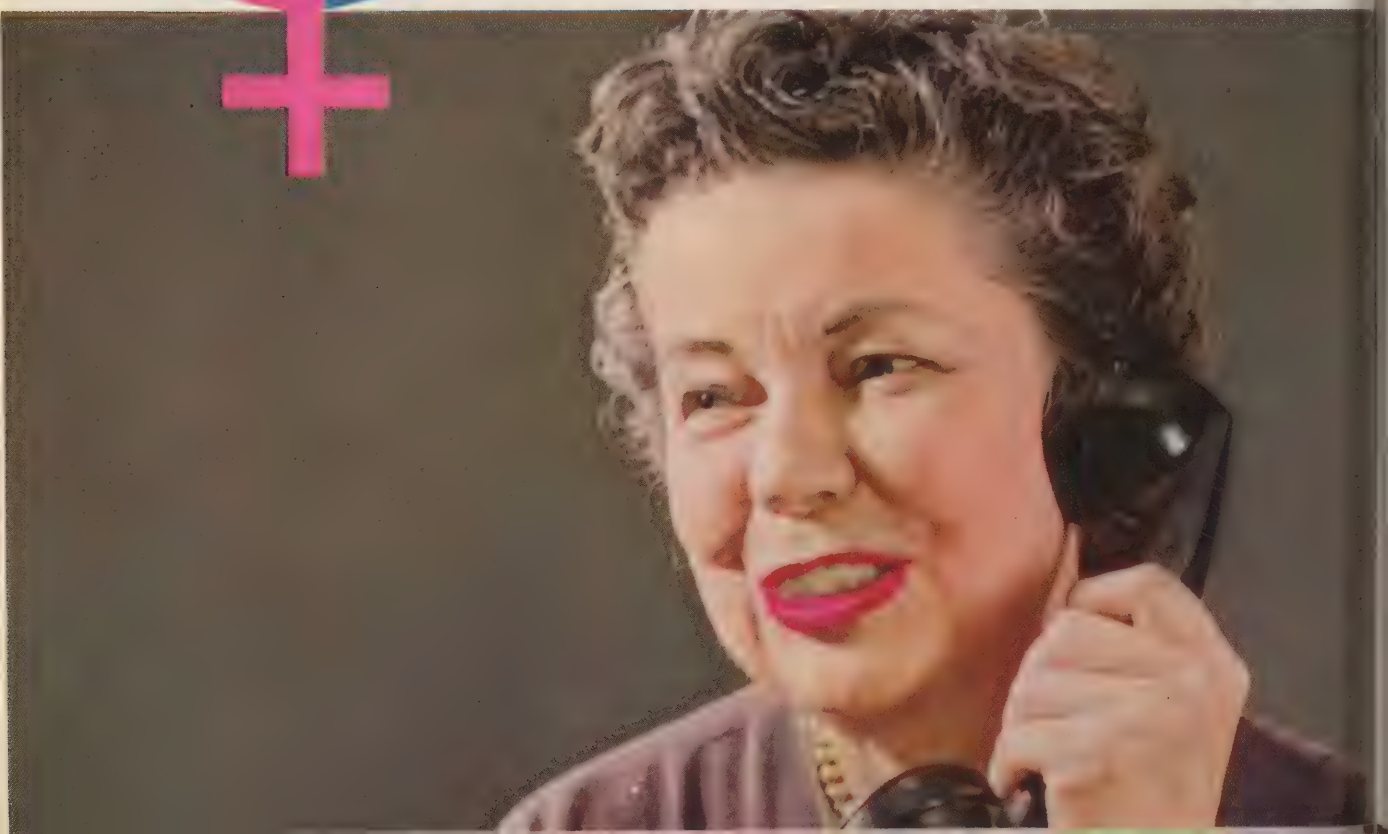
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Three Unusual Cases of Ectopic Pregnancy

Secondary Abdominal; Primary Ovarian; and Rupture Into the Broad Ligament

J. L. STAUF, M. D., J. H. HOLZAEPFEL, M. D., and E. M. NEWKIRK, M. D.

THE following case reports are prompted by the occurrence of an ovarian pregnancy and an abdominal pregnancy. These three patients were admitted to St. Ann's Hospital For Women. St. Ann's Hospital is an Obstetrics and Gynecology Hospital. The admissions on the Gynecology Service from July 1, 1954 to July 1, 1955 numbered 962. There were 3,432 deliveries during this same period.

Of the patients admitted on the Gynecology Service, eleven had ectopic pregnancies found at laparotomy. Eight others were admitted with the diagnosis of possible ectopic pregnancy but were eventually found to have other pathology. Of the eleven with ectopic pregnancy, one was a secondary abdominal pregnancy, one was a primary ovarian pregnancy, and one was a tubal pregnancy which ruptured into the broad ligament and then into the abdominal cavity.

According to Danforth[1] about 70 true primary ovarian pregnancies have been recorded. The incidence of abdominal pregnancy according to Quilliam[3] is one in every 12,500 pregnancies.

Case 1. Mrs. A is a 31 year old gravida II, Para 0, colored female who was admitted August 18, 1954. Her chief complaint was intermittent lower abdominal pain, and recent chills and fever. Her last normal menstrual period was in December 1953. Three days after her expected period in January she experienced severe colicky lower abdominal pain. Secondary signs of pregnancy were present. In March, 1954, she had a second episode of lower abdominal pain associated with mild vaginal bleeding and was admitted to another hospital for observation and treated conservatively.

In May, 1954 she was again admitted to still another hospital with pain and chills, and was in shock. 1500 cc. whole blood were required to stabilize her blood pressure and bring her count to a normal range. The patient refused to have an exploratory laparotomy. She felt this was her only opportunity to carry a child and she did not want any possible threat to it. Fetal heart tones were heard on this admission and the patient had felt movement and laparotomy was postponed. Ten days prior to this admission the patient had again observed severe back pain and chills. No fetal movement was felt by the patient following this.

On admission examination the patient was found to have a lower midline abdominal mass extending just above the umbilicus. The skin over the lower abdomen appeared tense and was extremely tender. No fetal movements were felt and no fetal heart tones were heard although they had been just ten days previously.

Anteroposterior and lateral x-rays of the abdomen were taken and showed a small fetus with evidence of fetal death. (See Fig. 1, and Fig. 2.)

On the day following admission the patient was taken to the operating room where exploratory laparotomy was performed. On opening the peritoneal cavity an abdominal pregnancy was found located lying in the false pelvis with the placenta attached to the right broad ligament, cecum, and small bowel mesentery. Following extraction of the macerated, stillborn fetus the umbilical cord was clamped close to its placental origin with the thought of leaving the placenta in situ due to its complicated implantation.

The placenta and cord had undergone some degeneration and in clamping the cord it was slightly separated from its attached surface. To control the resultant hemorrhage four figure-of-eight sutures of number 0 chromic catgut were placed in the placenta. The abdominal wound was closed by marsupializing the placental edge.

In the immediate postoperative course the patient continued to bleed and it was decided to pack the wound which had been marsupialized and place sand bags over the packing. Following this procedure the hemorrhage was controlled and the packing was removed on the second postoperative day. The patient then continued to recover without further complications and was discharged on September 4, 1954 (fifteenth postoperative day). The wound gradually closed in five weeks following the procedure. She has since developed a small midline ventral hernia but has had no complications from this.

Comment

This case, we feel, is most interesting from the method used in handling the placenta. Although marsupialization is in a general sense outmoded, we feel there are certain instances in which removing the placenta presents too great a hazard to the patient. Also, packing may be needed to control hemorrhage. Marsupialization allows one to do this.

We have reviewed 10 reports of abdominal pregnancy in the literature. Siegal lists three main

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- **Dr. Newkirk, Columbus, is a member of the active staffs of St. Ann's Hospital for Women and St. Anthony's Hospital.**

points in the diagnosis of abdominal pregnancy: "(1) The history in early months, of supposed miscarriage, accompanied with possible passing of shreds of tissue. (2) Palpability of the fetal parts suspiciously close to the abdominal wall. (3) Shortness and emptiness of the uterine cavity on examination." He states that usually there is no Hegar's sign, but he also states that diagnosis of abdominal pregnancy is much more difficult in its later stages.



FIG. 1. Lateral film of the pelvis and abdomen showing evidence of fetal death.



FIG. 2. A-P view of the pelvis and abdomen.

We would like to emphasize the importance of pain, in the past history of a patient, during the later stages of abdominal pregnancy. This is especially true in cases of secondary abdominal pregnancy with pain associated with the rupture or abortion through the tube and secondary implantation early in the history. Such was the case in this patient.

Case 2. Mrs. B, 34 years old, gravida II, Para 0, was admitted February 28, 1955, with the chief complaint of abdominal pain. Her last menstrual period was December 21, 1954. She had had two episodes of vaginal spotting; January 25, 1955, and February 10, 1955, accompanied by rather severe low abdominal pain which was only partially relieved by codeine. Four days prior to admission the pain became more localized to the left lower quadrant and became more constant and gradually increasing in intensity. Pain associated with bowel movements was present. For three days prior to admission she had been bedfast with pain, nausea, vomiting, and chills.

On initial examination the patient appeared pale and acutely ill. Blood pressure, 100/40; temperature, 99.6°; pulse, 120; respirations, 24. The abdomen was tense, distended, and there was generalized abdominal tenderness, greatest in the left lower quadrant with rebound tenderness and referred pain to this area. Bowel sounds were decreased. On pelvic examination the uterus was enlarged to the size of a three month pregnancy, irregular, and retrocessed. No bulging of the cul-de-sac was noted. The adnexae were difficult to palpate due to exquisite tenderness.

Admission blood count was red blood cells, 2.4 million; white blood cells, 11,700; neutrophils 84; lymphocytes 16; hemoglobin, 6.8 grams. Urinalysis was normal.

The patient was typed for four units of whole blood and taken to the operating room where laparotomy was performed. The preoperative diagnosis was ruptured ectopic pregnancy. The abdomen was entered through a low midline incision and the peritoneal cavity was found filled with clotted and unclotted blood estimated at 1,000 cc. The adnexae were explored for the source of bleeding and the right tube was found to be a hydrosalpinx. The right ovary was normal. The left tube appeared normal except for perisalpingeal adhesions. The left ovary was enlarged, ovoid, and approximately 8 cm. in length by 6 cm. in diameter. The surface appeared bluish and in one area had ruptured. A small placenta was extruding through the area of rupture and was the source of hemorrhage. A left salpingo-oophorectomy was performed. The patient received four units of blood.

In the immediate postoperative period the patient did fairly well except for moderate abdominal distension and nausea for which a Levin tube was inserted into the stomach. She continued to improve and was discharged home on March 7, 1955 (seventh postoperative day). The pathologic tissue diagnosis was left ovarian pregnancy.

Comment

In view of the extreme rarity of primary ovarian pregnancy and Spiegelberg's Criteria, i. e., (1) Tube and fimbria distinctly separate from the ovary, (2) Gestational sac must occupy the normal position of the ovary, (3) The sac must be connected to the uterus by the utero-ovarian ligament, and (4) Unquestionable ovarian tissue must be present in the walls of the sac, we feel that

these criteria have been fulfilled in this case and that it is thus reportable as such. (See Fig. 3, and Fig. 4.)

Case 3. Mrs. C, 32 years old, gravida V, Para III. Last normal menstrual period was August 21, 1954—admitted to hospital on October 18, 1954. The patient had a history of normal regular menstrual periods. One week before admission she had taken three grains of quinine in a self-attempted abortion and had developed moderate lower abdominal cramping pain. Four days prior to admission she had passed several blood clots and on the day of admission had noted the sudden onset of severe localized right lower quadrant pain. She had fainted just prior to having been brought to the hospital. She had no shoulder pain or history of pain with defecation.



FIG. 3. Photomicrograph showing tubal mucosa, ovary, and chorionic villi. Area enclosed by box may be seen under higher magnification in Fig. 4.

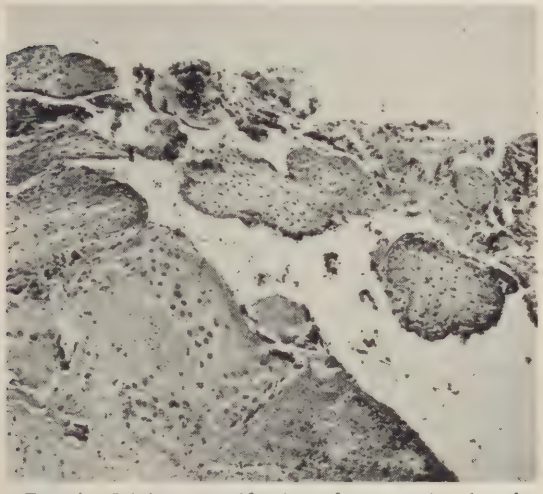


FIG. 4. Higher magnification of area enclosed in box in Fig. 3. This shows in more detail the chorionic villi.

Initial examination revealed blood pressure, 100/60; temperature 98.6°; pulse, 88; respirations, 20. She was pale and in acute distress. The abdomen was distended and guarding was present in the right lower quadrant, with associated rebound and referred pain to this area. Shifting dullness was noted to be present 12 hours following admission. *Pelvic:* The cervix was closed and a small amount of blood was exuding from the os. The uterus and adnexae were difficult to examine.

Admission blood count: Red blood cells, 4.29 million; white blood cells 12,350 with 6 stab forms, 75 segmented cells, 19 lymphocytes; hemoglobin, 12.5 grams. Urine showed white blood cells, 2 to 3 per high power field; trace of albumin. Twelve hours later the red blood cell count was 3.24 million; white blood cell count, 6,850; hemoglobin, 9.4 grams.

She was therefore taken to surgery and on opening the peritoneal cavity gross blood was observed. The right tube was distended by a mass 4 cm. in diameter which had ruptured posteriorly into the broad ligament and thence into the abdominal cavity. The patient received two units of blood and did quite well following a right salpingectomy.

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Development of Folliculitis in Patients Receiving Cobalt

Investigative work, primarily by Faguet, at the Pasteur Institute, has given a plausible explanation for the development of folliculitis in patients receiving cobalt. Faguet noted that the addition of small quantities of cobalt chloride increased the growth and multiplication of *Staphylococcus aureus* in cultures.

It is significant that these same studies, as well as others by different investigators, indicated that when penicillin, streptomycin or bacitracin were added to such cultures of staphylococcal aureus containing cobalt, the inhibitory effect of the antibiotic was enhanced two to ten times. This probably is due to the fact that these antibiotics act on the bacteria during their dividing stage. No benefit was noted in similar cultures combined with oxytetracycline, chlortetracycline, chloramphenicol or polymyxin.

Since cobalt is tightly bound to the cyano group in cyanocobalamin, the mechanism of its action in aggravating folliculitis cannot be explained on the basis of the experimental work cited. Further investigation will be necessary to explain the increase in activity of acne in patients receiving vitamin B_{12} preparations.—Chester M. Sidell, M. D., et al., Los Angeles: *California Med.*, 88:20, Jan., 1958.

Retrolental Fibroplasia

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness, which can in many instances be averted by proper, timely care.

Case Report

The patient, an 8 month old boy, weighed 3 pounds 15 ounces at birth. Duration of pregnancy is reported as seven months. Supplemental oxygen was given for three days, in unknown concentration. Ophthalmologic consultation in the hospital indicates that both eyes were completely normal shortly after birth. No maternal disease or familial eye pathology is known.

At the age of 6 months, this child was recognized to have markedly impaired vision. Re-examination at this time showed marked traction bands which displaced the large central retinal vessels into a temporal origin from the disc. These fibrovascular membranes swept across the macular area, obviously destroying central vision. Much of the peripheral retina was quite normal. It could, therefore, be predicted that the child would have side vision, but could not develop useful detailed central vision such as is necessary for reading.

Discussion

Retrolental fibroplasia is a disease resulting from modern medical care. It occurs almost exclusively in premature infants who have received supplemental oxygen. At the time of premature birth, the peripheral retina has not yet developed its blood vessels, and is dependent upon the choroid for nutrition. Supplemental oxygen inhibits the growth of the immature retinal vessels and makes the developing retina dependent upon the choroidal circulation.

With continuing growth, an acute need for additional retinal vessels develops, and neovascularization spreads wildly and rapidly over the inner retinal surface. This may leave minimal residual damage, central vision may be destroyed by fibrovascular membranes as in this case, or the whole retina may become detached and pulled forward to produce the "retrolental" membrane. No therapy is known to be effective once the disease has manifested itself.

During the past decade about half the children attending our blind schools were there because of retrolental fibroplasia. Almost complete elimination of new cases was accomplished following the proof that supplemental oxygen is the cause of retrolental fibroplasia. It is extremely hazardous to use oxygen in the care of premature infants, except when obvious cyanosis or other evidence of anoxia exists. Oxygen concentrations in excess of 40 per cent are particularly likely to result in retinal damage.

Particular attention should be directed to the fact that routine supplemental oxygen does *not* increase the survival rate of premature children. Clinical application of this knowledge has provided dramatic proof of the value of research in preventing blindness.

The Author

● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

Factors Predisposing Development Of Thrombosis

In summing up the role of anatomical change in the blood vessel walls in the pathogenesis of thrombosis, it is difficult to escape the conclusion that the logical explanation for the formation of most thrombi is lodgement of platelets at a spot of injury to the endothelium. Certainly the exposure of the coagulable circulating blood to an injured or dead surface of a blood vessel is the starting point of most thrombi.

A sclerotic patch in the coronary arteries which undergoes necrosis, rupture, or hemorrhage; an infected cranial sinus in otitis media; the uterine veins in puerperal sepsis; the portal branches leading away from an abscess; an infected thrombus on a heart valve; an infected thrombus on a venous valve are all examples. Non-infectious trauma, panarteritis, thromboangiitis, and atherosclerosis predispose thrombosis, just as phlebosclerosis, trauma, varicosities, and infections of veins precede thrombosis in many instances.

Now, aside from injury to the vessel wall, it is widely recognized that the modification of the velocity and direction of blood flow is of greatest importance.—Chester S. Keefer, M. D., Boston: *J. M. A. Georgia,* 47:55, February, 1958.

The Management of Syphilis

EVAN W. THOMAS, M. D.

THE sharp decline in the incidence and prevalence of syphilis starting in 1947 has now begun to level off. In 1956, for the country as a whole, there was a slight increase of newly reported cases over 1955. A decrease of late cases should be anticipated in the future, provided case-finding measures are promoted, but it is unlikely at present that the incidence of early syphilis will show further significant declines in the near future because we have no effective means of preventing infections other than treating known cases. How unsatisfactory this is can be shown by the fact that in normal years primary and secondary syphilis represents less than 5 per cent of the total number of newly reported cases. This means that each year many newly acquired infections go unrecognized.

The advent of penicillin has dramatically lowered the number of patients suffering from symptomatic late syphilis. Nevertheless, far too many patients are still admitted to mental hospitals because of advanced neurosyphilis. Late symptomatic syphilis can be prevented in almost 100 per cent of cases, if treatment is given before manifest symptoms develop. But, before treatment can be given, syphilis must be found and diagnosed, and there is no prospect that we can relax this campaign in the foreseeable future.

Syphilis is now confined largely in the lowest socio-economic groups. Few physicians see many cases in their private offices. Yet, over 200,000 newly reported cases were recorded in 1956 and the medical profession cannot ignore a disease with this prevalence. Every physician should know the fundamentals in the diagnosis and treatment of syphilis, and every physician should cooperate with public health departments in the epidemiology of infectious cases. The purpose of this paper is to outline as briefly as possible the essentials in the diagnosis, treatment and epidemiology of syphilis. Each topic will be outlined separately.

I. Diagnosis

Syphilis comprises almost two distinct diseases —the early and late stages. Early lesions are infectious, but they are always self-limited and they are, as a rule, nondestructive. Late lesions, when they occur, are relatively noninfectious, but they are chronic and destructive. In all probability the untreated infectious stage rarely lasts more than two years, and oftentimes for much shorter periods. For epidemiologic purposes, the early infectious stage is of primary importance, but it is the late manifestations of the disease that make it a menace to the individual and to society. Without going into any detail, the essentials in the diagnosis of various types of syphilis follow:

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Primary stage (chancre at site or sites of infection. Chancres are usually single but they may be multiple). Diagnosed by:

1. Finding the *Treponema pallidum* in serum from the chancre by dark-field microscope.
2. Serologic tests for syphilis (STS). Tests may be negative early. In the presence of a suspicious early lesion, STS should be repeated frequently for at least 2 or 3 weeks. When the STS begin to be positive, the titers of quantitative tests rise rapidly within a few days. Syphilis should be ruled out in the presence of any genital lesions.
3. History of exposure.

Secondary stage (initial reaction of tissues to the *T. pallidum* carried to the tissues by blood and lymphatics). Diagnosed by:

1. Dark-field microscopic examination of serum from lesions.
2. Positive STS. Seronegative secondary syphilis, if it occurs at all, is so rare as to be negligible. The titers of quantitative tests are usually high, but individuals vary greatly in the amount of reagin formed. In the absence of demonstrable lesions, secondary syphilis should not be diagnosed but secondary lesions may be scanty and faint as well as profuse and obvious. In the absence of positive dark-field examinations, a diagnosis of secondary syphilis should be made with caution, if the STS titers are positive in dilutions of less than 1 to 2.

Early latent (asymptomatic) stage (less than 2 years' duration).

Authorities differ over the definition of early

Presented at a Physician's Venereal Disease Seminar, held at the Newton D. Baker Health Center in Cleveland, January 8, 1958.

latent syphilis. For epidemiologic purposes some make it of less than 1 year duration, others of less than 2 years and still others of less than 4 years. It is diagnosed by:

1. Positive STS. As a rule, the earlier the infection, the higher the titers.

2. History. Without an accurate history of previous STS or of possible exposure to infection, the duration of the infection is at best a guess. Relatively high STS titers in young people, especially teen-ages, suggest a diagnosis of early latent syphilis. The following information should be sought from every patient suspected of having syphilis, regardless of the stage:

a. History of genital lesions or of skin and mucous membrane lesions.

b. History of previous STS—dates, where taken and results of reactions.

c. History of possible previous treatment for syphilis. In many cases it is wise not to mention syphilis in questioning patients, but to ask about tests for "bad blood" and "needle treatments" or "hip shots" (how many and how frequent).

Late latent stage (asymptomatic late syphilis. Diagnosed by:

1. Positive STS. Titers are usually relatively low.

2. History. (See above.) Seropositive patients who deny the possibility of syphilis should have repeated STS for at least a month or more and, if possible, a treponemal immobilizing antibody (TPI) test, or some other specific test to rule out false positive STS. If specific tests are unavailable, it is better to treat a patient with persistently positive STS than to guess that the positive STS represent biologic false positive reactions.

Asymptomatic neurosyphilis. Diagnosed only by:

1. Positive spinal fluid examinations which should consist of:

a. Complement fixation test for syphilis (Wassermann) or VDRL,

b. Cell count,

c. Total protein determination,

d. Colloidal gold or other colloidal tests.

The least valuable of these tests is the colloidal curve which provides no reliable information about the activity of neurosyphilis. Activity is best represented by cell counts of more than 4 or 5 per cu. mm. of fluid and oftentimes by increased total protein determinations (more than 40 mgs. per 100 ml.) in association with positive VDRL or complement fixation (Wassermann) tests of the spinal fluid.

If spinal fluid examinations are not made, asymptomatic neurosyphilis cannot be diagnosed, but adequate treatment is possible without spinal fluid tests even if neurosyphilis is present. Positive STS titers of the blood are likely to be higher in patients with asymptomatic neurosyphilis than in those with latent syphilis, but this is not a reliable means of diagnosis.

Symptomatic neurosyphilis. Diagnosed by:

1. Signs and symptoms of neurosyphilis, especially pupillary changes (unequal pupils, irregularity of pupils, poor or no reaction to light).

2. Positive spinal fluid tests (see above).

3. Blood STS are positive, often in relatively high titers in active untreated cases, with the exception of tabetics whose STS may even be negative.

Cardiovascular syphilis. Diagnosed by:

1. Evidence of dilated aorta on fluoroscopy or x-ray films (not always diagnostic).

2. Physical signs of aortic insufficiency not explained by other causes.

3. Positive STS (titers may be low or high).

Gummatous reactions. Diagnosed by:

1. Signs of gummatous reactions or tertiary syphilides in the skin, mucous membranes, bones, liver, stomach and other organs except ovaries and intestines.

2. Positive STS (titers are usually very high).

Prenatal syphilis. Diagnosed by:

1. Positive STS.

2. History is important.

Congenital syphilis of the newborn. Diagnosed by:

1. Signs of secondary lesions (skin, mucous membranes, bones).

2. Positive STS which, in the absence of lesions, persist for 3 months. Passive transfer of reagin from mother to fetus occurs. A seropositive mother previously treated for syphilis may transfer reagin to the fetus without the fetus being infected. In that case the baby's STS will be positive but titers will decline without treatment and become negative within 3 or 4 months. Rising titers of the baby's STS indicate congenital syphilis.

Late congenital syphilis. Diagnosed by:

1. Positive STS.

2. History of patient and of parents.

II. Treatment

The following schedules of treatment are minimal, but they can serve as guides for routine use:

Treatment of early syphilis (primary, secondary and early latent).

1. Benzathine penicillin G—2,400,000 units

given in a single treatment by injections of 1,200,000 units in each hip.

2. Procaine penicillin in oil and aluminum monostearate (PAM)—4,800,000 units given by individual injections of 1,200,000 units every 3 to 5 days.

Treatment of late latent (asymptomatic) syphilis.

Same as above but, if no spinal fluid examination is obtained, treatment should consist of at least 4,800,000 units of PAM in order to arrest possible asymptomatic neurosyphilis.

Treatment of asymptomatic neurosyphilis.

See above. Some authorities prefer total doses of 6- rather than 4.8-million units of PAM.

Treatment of symptomatic neurosyphilis and cardiovascular syphilis.

Total dose of 4,800,000 units PAM will suffice for many cases, but most authorities advise total doses of from 6 to 9 million units, especially for general paresis and cardiovascular cases. Individual injections of 1,200,000 units can be given every 3 to 5 days.

Treatment of prenatal syphilis.

Treatment should be the same as for other types of syphilis. If the pregnant woman has had previous antisyphilitic therapy and is still seropositive, further therapy may not be necessary but, when in doubt as to the adequacy of previous treatment, re-treatment is advised.

Treatment of congenital syphilis of newborn.

Injections of 150,000 to 300,000 units PAM every 3 days for 3 or 4 injections will usually suffice. Oral penicillin, 100,000 units per kilogram of body weight daily for 14 days has been advised by some authorities in Germany.

Treatment of late congenital syphilis.

Same as for acquired cases.

Treatment of penicillin-sensitive cases.

Erythromycin or Magnamycin® is preferred. Other antibiotics can be used, but the *T. pallidum* is more sensitive to the first two above than to chlortetracycline, oxytetracycline and chloramphenicol, any of which can be used. Oral treatment with from 250 to 500 mg. of erythromycin every 6 hours can be given for 8 to 10 days in early cases and for 10 to 15 days in late cases. Intramuscular injections of 750 mg. to 1 gram of erythromycin daily for 8 to 10 days in early cases and for 10 to 15 days in late cases might be tried but no data on this treatment are available. If chlortetracycline or chloramphenicol is chosen, individual doses of at least 500 mg. should be given orally as advised for erythromycin.

Evaluation of Treatment

Following therapy of primary and secondary syphilis seronegativity is usually obtained within one year. However, some 20 per cent of patients treated for secondary syphilis may have positive STS in low titers for more than one year. Retreatment is not advised unless the STS show marked increases from previous levels (serorelapses).

Patients treated for late syphilis usually continue to be seropositive for years after treatment. No patient should be retreated solely because of positive STS unless there is evidence of marked increases in titers from previous levels.

Therapy of neurosyphilis is best evaluated by serial spinal fluid examinations but these examinations are of little use unless careful cell counts and total protein determinations are made. Cell counts should be normal 6 months after successful therapy and there should be a decline in abnormally high total protein.

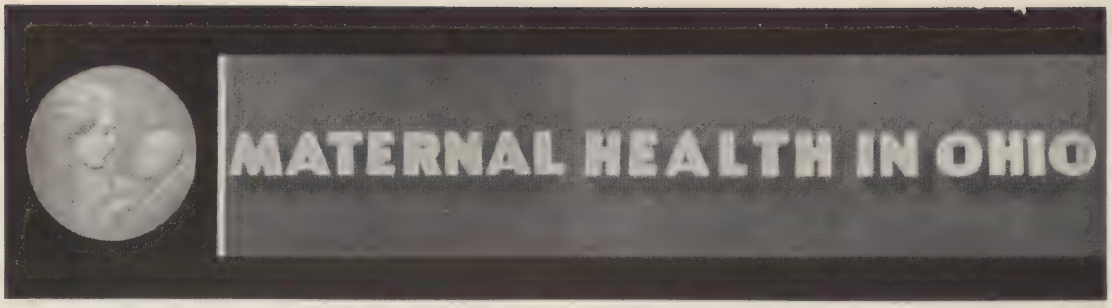
III. Epidemiology

Epidemiologic programs apply to early infectious syphilis. The program includes:

1. Prompt reporting of early cases to health departments.

2. Interviewing cases for contacts. Whenever possible this should be done by trained venereal disease investigators provided by health departments. Physicians should make it possible for patients to be interviewed. This can be done without loss of confidence on the part of the patient. Health department personnel are well aware of the necessity for tact and strict observance of the confidential aspects of syphilis. Embarrassment to both patient and physician can be avoided when there is cooperation between physician and health department. Only by means of interviewing patients for contacts can the reservoir of infectious syphilis be held in check.

3. Contacts of infectious cases must be brought to medical examination. This is the responsibility of health departments. Contacts can be referred to private physicians for examination when this is desired or they can be examined in clinics chosen by the health department.



TOPIC THIS MONTH:

Maternal Deaths* Involving Infection

Case No. 60

The patient was a 35 year old, white, gravida II, abortus I who died two days postpartum. Her past history was essentially negative except for dilatation and curettage following an incomplete abortion, later followed by bilateral salpingo-oophoritis. Three years following this infection she became pregnant. Onset of last menstrual period was October 15 and she consulted her doctor when she was two months pregnant; calculated date for term was July 22. There were no complications during pregnancy until July 11, when her doctor could not detect any fetal heart tones. X-rays were completed but there was no report of the findings.

On July 16 she was admitted to the hospital and an attempt to induce labor by the use of Pitocin® was unsuccessful. On July 22, in an attempt to induce labor, the membranes were artificially ruptured. When uterine contractions did not develop after 12 hours, under Trilene® anesthesia, the cervix was manually dilated and the uterine cavity emptied of grossly infected material —(nothing is said concerning the condition of the fetus and placenta other than that delivery was rapid). During this operative procedure the patient developed a severe, prolonged, shaking chill.

Following this the patient pursued a septic course, developed jaundice, albuminuria—later anuria, and a pericardial friction rub. Laboratory studies revealed 4 plus albuminuria; pyuria; nonprotein nitrogen, 54.6; blood urea nitrogen, 156. She died on July 25, on her ninth hospital day. An autopsy was performed.

Cause of Death: Uremia following septicemia, stillborn fetus.

Pathological Diagnosis: The autopsy disclosed acute suppurative pericarditis, granulomatous myocarditis, bronchopneumonia, and multiple hemoglobin casts in the kidney tubules indicating that the jaundice was of hemolytic type. Section of the fallopian tube showed marked thickening of the wall and extensive inflammatory cell infiltration. There was necrosis and a fibropurulent exudate. Section of the myometrium showed even more extensive inflammatory exudate and abscess formation.

Comment

Again, members of the Committee felt hampered in efforts to properly evaluate features in the case, because of a lack of certain facts in the history (previous abortion) and omission of important laboratory findings. In view of previous infection in the pelvis, it would have seemed proper to initiate heavy antibiotic therapy prior to terminating the pregnancy. Members of the Committee did not concur in the forceful intervention employed to empty the uterus; it was assumed that the fetus was macerated. The case was voted a preventable maternal death.

Case No. 141

The patient was a 25 year old Negro, cesarean I, abortus I, who died 49 days following delivery by low cervical cesarean section. Her past history is not remarkable. One previous pregnancy, spontaneous abortion 16th week of gestation. She was first examined when two months pregnant and estimated date for term was January 7 to 10. She was in good physical condition and subsequently the pregnancy followed a normal course with a weight gain from 150 to 176. Blood pressure varied from 110/60 to 150/70. While there was no detailed information concerning the pelvic measurements, apparently the attending physician considered the pelvis adequate for vaginal delivery.

On January 6 she was admitted to the hospital in active labor; the *membranes had ruptured* several days before. Her general physical condition was good, blood pressure 120/55 and hemoglobin 11.4 grams. After eight hours of active labor the head was not engaged, a large caput succedaneum was felt, and fetal bradycardia developed. A low cervical cesarean section was performed, uneventfully, under spinal anesthesia; a healthy 6 pound, 4 ounce baby was delivered. Subsequently the patient's temperature ranged up to 103 degrees for three days. A similar rise occurred on the ninth to twelfth postoperative days. Nausea and vomiting developed. Abdominal x-ray films revealed evidence of paralytic ileus. Penicillin and streptomycin was started on January 8 and continued to January 17. Then erythromycin was administered but discontinued as patient developed diarrhea with stools laden with *Staphylococcus albus.*

She had recurrent attacks of nausea, vomiting, distention and diarrhea. Marked pyuria, anemia, and azotemia developed. She complained of chest pain and a systolic murmur was heard at the apex and base of heart. Re-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

peated electrocardiograms revealed progressive T wave changes. There was some improvement with repeated blood transfusions, oxygen, Demerol,® and digitalis. In addition to the usual laboratory work, multiple tests were performed, including bone marrow aspirations, blood indices, icteric index, red blood cell count, fragility, malarial smears, Coombs test, and multiple blood cultures with negative results. She became disoriented and somnolent. Cortisone therapy was instituted, but was of no avail. She died on February 26—49 days following delivery. Autopsy permission was obtained.

Cause of Death: Overwhelming septicemia. (From certificate): "Renal failure and heart failure."

Pathological Diagnosis: The (lengthy) final report included principally:

(a) Thrombosis of vesico-uterine plexus;
(b) Fibrinous pericarditis and mural thrombosis of atria and left ventricle;
(c) Marked hemosiderosis and erythropoiesis of spleen;
(d) Acute diffuse membranous glomerulosclerosis of eclampsia;
(e) Either passive congestion or thrombo-embolism, fatty necrosis, necrotizing arteritis or multiple infarcts involving every organ of the body.

Comment

The very informative report covering the records of this case is commendable, indeed. The Committee voted the case a nonpreventable death. Prenatal care was adequate, as was the care during labor, delivery, and the postpartum period. Complete and repeated diagnostic studies were made during hospitalization, and just as much interest was taken in therapy. A very complete autopsy confirmed the diagnosis of an overwhelming septicemia.

It is generally considered that premature rupture of the membranes with delay of several days before the onset of labor may occur without untoward consequences, however, many of our older physicians do not consider it so lightly. Before the availability of the "antibiotics" in all cases where delivery by section was being considered, every effort was made to complete the delivery within a 12 hour period following rupture of the membranes. The longer the delay the greater the morbidity due to infection.

The Committee felt that in this case antibiotics should have been started promptly on her admission to the hospital, but most certainly they should have been given when delivery by section was contemplated.

Case No. 101

This patient was a 31 year old white gravida VI, Para IV, who died about five weeks postabortal. Very little could be ascertained concerning her past history. It was learned that she had had four term pregnancies previously delivered without complication. Four years before she had had a miscarriage, the details of which were not known. Her last menstrual period occurred August 4, according to the record. On October 2, the patient entered the hospital with an infected abortion allegedly self-induced by the introduction of a catheter. Details on her physical examination and laboratory findings were not recorded.

It was learned that she received blood, Gantrisin,® Terramycin,® Combiotic® therapy, and later the same day of admission she submitted to a dilatation and curettage. After three days of fever (details not known), the temperature became normal and the patient was discharged on October 8 in excellent condition with a normal temperature. However, soon after the patient arrived at home she developed chills and fever and became gradually worse. For one week prior to her readmission, she developed chest pains and productive cough.

The patient was re-admitted to the hospital on November 5; it is stated that her pelvis was negative, but examination of her chest revealed signs of a subacute bacterial endocarditis, septicemia and pulmonary infarct. Details of her treatments were not recorded. However, in spite of heroic efforts and extensive therapy, the patient became progressively worse and died November 12. Autopsy permission was not granted.

Cause of Death: Subacute bacterial endocarditis; abortion, infected, allegedly induced. (Sepsis not mentioned.)

Comment

Members of the Committee studied this case with a great deal of interest. The responsibility of the patient in allegedly submitting to a criminal abortion was noted. However, the Committee felt that there was questionable indication for a dilatation and curettage in the face of severe uterine infection on the day of admission, especially since no note was made of its dire need. It was felt that in view of the information provided, the patient should have been treated expectantly until the greater part of the infection was overcome. The Committee voted this a preventable maternal death.

Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was given at the request of the Committee.

In the basic classification of "complications of pregnancy (hemorrhage, toxemia and sepsis), it is a matter of record that improved obstetrical care and new armamentaria have reduced maternal mortality. Blood banks, increased care in the antepartum period, and the advent of chemical and antibiotic agents have been applied respectively to these three hazards. Probably the greatest of these advances has been in the field of sepsis. It is most important, that we take fullest advantage of all three, but it is becoming more and more a moral and legal responsibility that we employ the fullest measure of care in applying principles of antisepsis and therapy in care of such cases.

Case No. 60: The relationship of "previous abortion," mentioned in the history, probably is inconsequential. This had occurred three years prior with no record of recurrent infection during the interval, and certainly was of a degree not sufficient to prevent the pregnancy of the patient under discussion. The "manual dilatation" in

treatment, we feel to be radical. "Grossly infected"—why? Twenty-four hours after ruptured membranes and with the possible contamination at amniotomy, especially when autopsy suggests hemolytic streptococcus as the infectious agent, may have been contributory. Another attempt at induction with Pitocin® would have been more appropriate in our opinion. The repeated attempts carry a fair percentage of success. The risk of "dead foetus syndrome" with possible afibrinogenemia is, percentagewise, a better risk.

Impression: Preventable death.

Case No. 141: The comment of the Committee covers the situation adequately. The only possible improvement in care might have been institution of antibiotic therapy at time of rupture of the membranes. This one addition certainly would qualify the case for classification as nonpreventable.

Case No. 101: Again, the Committee has summarized the opinion of the consultant. This case is an excellent one in point of emphasizing the wisdom and necessity of conservative approach in care of an infected abortion. The case qualified as "preventable" when the patient submitted to the criminal abortion, but was further qualified for same when the attendant did a dilatation and curettage in the face of symptoms of sepsis without (recorded) emergency from blood loss. If the patient's greatest immediate hazard had been hemorrhage, the dilatation and curettage might have been advisable. As the record stands, the death must be classed as preventable.

Influence of Nutrition to Control Tumor Incidence Is Studied

The work of McCay's classic experiments on the prolongation of life and the relative lack of degenerative changes in underfed animals suggests the possible lack of cancer susceptibility also. Much effort has been expended on this approach towards the control of tumor incidence and in many cases the induction period of tumors has been delayed and the growth rate of established tumors retarded by various forms of dietary depletion.

How drastic the dietary regimens may be to effect such changes, and what is the cost in terms of the natural processes of the animal, are yet to be answered. If one knows a cell's peculiar dietary needs and they differ from those of other cells—then a scientific hurdle is crossed.

This is the principle of antimetabolite action upon which the sulfa drugs work. There are some principles now established for cancer cells in animals and, in some instances, cancer cells in humans.—George C. Hall, M. D., Los Angeles: *Rocky Mountain M. J.,* 55:57, February, 1958.

Selective Readings . . .

Biochemical Individuality, by Roger J. Williams, Ph. D. ($5.75, *John Wiley and Sons Inc., New York 16, N. Y.)* That no two people are alike, an ancient and intuitive axiom, is recognized today as a scientific truth. Dr. Williams advances his genetotrophic concept, the simple principle that every individual organism with a distinctive genetic background has equally distinctive nutritional needs which must be met for optimal well-being. It is evident, for example, that some stomachs hold six to eight times as much as others with eating "habits" varying accordingly, or that some people live to a ripe old age relatively free from illness although from a nutritional point of view, they would be considered substandard.

Heredity, to begin with, imposes its patterns of size, health, and function. As the author proves, these anatomical, physiological, and biochemical differences already determine diverse interactions with the environment, no matter how benevolent or cruel that may be. Accordingly, if we could determine the particular needs of a person from the ovum onward, we could avoid malformation, susceptibility to infection and disease, and degeneration.

Dr. Williams believes it reasonable to assume that practically every human being is a "deviate" in some respects. This he proceeds to document with considerable evidence already available on anatomical variations, personal composition, enzymic and excretion patterns, endocrine activities, pharmacological manifestations, and individual nutritional requirements. Perhaps the leading clue to personal welfare hinges on the discovery of what, precisely, our differences consist of. It is the author's hope that the vast areas of reasearch implied here will be intensively explored.

Industrial Deafness: Hearing, Testing and Noise Measurements, by Joseph Sataloff, M. D. ($8.00, *Blakiston Division of McGraw-Hill Book Co., New York 36, N. Y.)* This work is intended for all who are concerned with industrial noises and their damaging effects upon the hearing and upon human behavior. It serves as a practical guide book in solving the numerous problems that arise in industry in relation to noise and therefore is invaluable to ear specialists, hearing testers, industrial physicians and executives, compensation lawyers, insurance executives, acoustic engineers, safety engineers, Chamber of Commerce executives, industrial nurses, industrial hygienists, and Labor Union leaders.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS white female high school student was admitted to University Hospital, Columbus, Ohio, for the first time at the age of 17, with a two-year history of chronic fatigue and vague joint pains and a three-month history of left upper quadrant abdominal fullness, inability to eat a large meal, anorexia with occasional nausea and vomiting, and a 10 pound weight loss over the last month. Previous personal and family history were unremarkable.

Physical examination revealed a slender white female appearing chronically ill, with scattered small ecchymoses over her extremities. She had a soft systolic murmur over the apex of her heart, and her moderately tender spleen extended 8 cm. below the left costal margin and to the midline. Her total white blood count was 5,200 with 40 per cent immature myeloid cells, 14 per cent reticulocytes and 18 nucleated red blood cells per 100 white blood cells. She had 385,000 platelets. Repeated bone marrow aspirations failed to recover marrow material.

The Hospital Stay

During her hospital stay the patient had an episode of epistaxis and passed bloody stools. She was treated with 4 units of whole blood and discharged on iron therapy.

She was admitted four months later because of general weakness and diffuse abdominal pain. Since her discharge she had received x-ray therapy. The physical examination revealed a pale skin with scattered ecchymoses over both lower extremities; systolic murmurs over the left sternal border and over the apex, and an enlarged spleen which filled the left half of the abdomen. Her total white blood count was 16,900 with 26 per cent immature myeloid cells. Her platelets numbered 212,000. Bone marrow aspiration failed again to recover marrow material. She was treated with Myleran® and discharged to the outpatient department.

She was admitted the following month because of weakness, left shoulder pain and increasing anemia (hemoglobin 5.5 Gm.). She had 6 per cent reticulocytes, 43,000 platelets, and 62 per cent of her myeloid cells were of the immature type. She was treated with 5 units of blood and Myleran was continued. Following the second unit of blood her temperature rose to 103° F. and the van den Bergh rose from 0.6/1.5 to 1.2/3.1 mg. Following discharge she continued to have fatigue and periodic left upper quadrant abdominal pain. Her platelets fell to 12,000 and the reticulocytes rose to 26 per cent at one stage. The Myleran was stopped temporarily and prednisone was given. Later Myleran was resumed and prednisone continued.

Presented by

- **Henry E. Wilson, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Because of her low red blood cell count of 1.79 million, the patient was readmitted for blood transfusions. At that time her hemoglobin was 7.4 Gm., her platelets 60,860. She had 13.4 per cent reticulocytes and 20 per cent of her 6,600 white blood cells were of the immature type. Attempts at bone marrow aspiration again were futile. X-ray examination of her skeleton showed a general increase of bone density with the suggestion of minute nodular densities within the iliac bones. During this admission a 1745 gram spleen was removed; her postoperative recovery was good and her platelets rose from 76,160 to 172,200.

Fifth Readmittance

Following her discharge the patient was well until four months later, when she was again admitted with suprapubic pain, urinary frequency, nocturia, dysuria, chills and fever. She also developed hematuria and a temperature of 102°F. She was found to have acute cystitis and enterococci were grown on urine culture. This time she had a hemoglobin of 10.1 Gm., 11.8 per cent reticulocytes and 28 per cent nucleated red blood cells; her total white blood count was 64,000 with 22 per cent immature cells and 214,000 platelets. Bone marrow aspiration again was unsuccessful.

She was again admitted two months later because of total urinary incontinence and gross hematuria. Chills, fever, hematuria and severe

right flank pain were again present. Cystoscopy showed an exudative cystitis with polyposis of the bladder mucosa and granular urethritis. Urinalysis showed hematuria and moderate growth of enterococci. Her hemoglobin was 3.3 Gm. with 9.2 per cent reticulocytes; her platelets numbered 888,000. She had 44,250 white blood cells with 37 per cent immature cells.

Two months later she suffered a flare-up of her urinary infection with enterococci and B. proteus in her urine and a temperature of 103°F. Her white blood cells numbered 29,000 and dropped to 14,000 in five days; her platelets numbered 1,025,000. She was febrile for five days. Four units of blood brought her hemoglobin from 6.2 to 11.6 grams.

Her eighth and last admission took place the following month. The patient had been well since her last discharge until one week prior to admission, when she developed swelling of the right knee followed by nausea, vomiting, cough and weakness. She was extremely pale, had a left sternal edge systolic murmur and bilateral upper abdominal quadrant tenderness. Her liver was enlarged to the iliac crest. She had a hemoglobin of 6.5 Gm., 1.0 per cent reticulocytes and 46 per cent nucleated red blood cells; her total white blood count was 28,200 with 62 per cent immature cells and 1,100,000 platelets. Her urine culture showed Klebsiella and Proteus. The blood urea nitrogen was 6 mg.; the serum amylase was normal. X-ray of her chest was unremarkable. She was treated for her urinary infection with Chloromycetin® with some improvement.

On the tenth hospital day she developed severe left upper quadrant pain with diminished bowel sounds, which improved after intravenous fluids. The x-ray of her abdomen showed no free air. On the eleventh hospital day she developed progressive periorbital edema with oliguria and that evening she suddenly became dyspneic and was found moribund with imperceptible pulse and heart beat and shallow, gasping respirations. Her blood count on the last day showed a hemoglobin of 11.2 Gm., white blood cells 28,000, platelets 762,960.

Clinical Discussion

Dr. Wilson: This girl was in good health until approximately the age of 15, when she commenced having chronic fatigue, vague joint pains and left upper quadrant fullness. Her condition was further aggravated by anorexia, occasional nausea and vomiting. At this point we might emphasize that you can often get anorexia, nausea and vomiting with splenomegaly alone regardless of its cause. It is probable that the increased pressure by the spleen on the lateral wall of the stomach precipitated her nausea. She had scattered small ecchymoses over her extremities, and these ecchymoses and some other more prominent hemorrhagic manifestations continued to appear in her subsequent history. The soft systolic apical murmur can very easily be interpreted as a hemic murmur.

The hemogram is very revealing. If we assume that this girl's red count was in the order of 2.7 million cells, her 14 per cent reticulocyte count would mean an enormous increase which was way out of balance. However, when we observe a high reticulocyte count in the presence of nucleated red cells in the peripheral blood, the usual significance of the reticulocytes is completely lost, and when you see this combination in the presence of large numbers of immature white cells, you have a phenomenon which has been named descriptively as leukoerythroblastic anemia. She also had white cells and bacteria in the urine which kept recurring and finally gave her a great deal of trouble.

Bone Marrow

Repeated bone marrow aspirations failed to recover any marrow material, and as you read through the history this keeps recurring like an old record. Nowhere did I notice that she had a surgical biopsy of marrow, and I must admit that we don't get surgical marrow biopsies as frequently as we ought. Then she is readmitted four months later with diffuse abdominal pain, probably caused by her enlarged spleen, and received some x-ray therapy for this. Her spleen must have been filling much of her abdomen. At this point we might well consider her blood picture.

Her hemogram was suggestive of a leukoerythroblastic anemia, which usually suggests a myelophthisic process due to something invading the bone marrow. The commonest process statistically is a metastasizing carcinoma, and you look for the ones that metastasize most frequently to bones, such as carcinoma of the breast, prostate, thyroid, lung or adrenal glands. About 5 per cent of multiple myelomas will produce this type of picture due to bone marrow displacement. Then there is a group of rather closely related, little understood lesions which have been called diffuse osteosclerosis, myelofibrosis with myeloid metaplasia or extramedullary hematopoiesis, and also agnogenic myeloid metaplasia, which can produce this syndrome of leukoerythroblastosis or leukoerythroblastic anemia.

Conversely, we do not see this sort of blood picture in granulocytic leukemias except as a complication. In chronic myeloid leukemia you

see a rather wide range of myeloid cells, but it is quite uncommon to see large numbers of normoblasts. In the acute type of granulocytic leukemia you see a greater uniformity of the immature cell type. There are a few cases of chronic leukemia that form thrombi in their bone marrows and produce the picture of leukoerythroblastic anemia, but leukemia is one of the last things I would think of in our patient.

They commenced treatment with Myleran, which is probably the treatment of choice throughout the world today for chronic granulocytic leukemia. It is also used for extramedullary hematopoiesis occurring in any one of these syndromes we have talked about. In some instances it has had quite a striking effect, reducing pain of splenomegaly, and we have seen quite a few dramatic improvements in the symptoms of this whole syndrome. But since Myleran depresses marrow activities, including hematopoiesis, I think we can blame Myleran for some of the developments which were observed at her third and fourth admissions. Her left shoulder pain makes you think among other things of a splenic infarction, which is a common occurrence in large spleens with extramedullary hematopoiesis. She was given blood transfusion and we can assume that she had a hemolytic reaction following her transfusion. During her fourth admission the Myleran was stopped and she was put on prednisone.

Splenectomy

Apparently the clinicians thought that the patient had too much trouble with her spleen, so they decided to have it removed. I would guess that her thrombocytopenia, the suspicion of a continuing hemolytic process which seemed to grow worse after transfusions, and possibly the pains suggestive of infarction, represented at least three indications for the removal of the organ. Apparently she did pretty well after that. Her platelet count went up, she made a nice postoperative recovery and was presumably in pretty good health for about four months.

Then she returned with more urinary tract complaints and chills and fever. The blood picture was reasonably good at this point, and she apparently had been thriving following her splenectomy. Somebody tried to aspirate some bone marrow again but again did not get anything. At her sixth admission they found polypoid lesions around the bladder neck, which probably meant that she had "exuberant cystitis." Her hemoglobin was much reduced at this point and she had quite an increase in her white blood cells. This would fit well with a very severe infection, possibly with some exacerbation of hemolysis. She returned with more urinary tract trouble and lots of fever. The platelets reached quite high levels.

After presumably having been well for almost a month, she returned for her eighth and last time with some swelling of her right knee and nausea and vomiting which cannot be explained this time by splenic pressure. Her liver had been enlarging progressively and now filled much of the right side of the abdomen. She was profoundly anemic and had a marked leukocytosis with immature white cells. Her urine culture was again positive for Klebsiella and Proteus.

Then something very serious happened and she collapsed. I don't know what may have caused this. It is apparent, I think, that this girl had a sepsis, it is apparent that she had some sort of a bleeding diathesis which we have never fully explained. She did not have any thrombocytopenia, and her prothrombin levels were never in the bleeding range, and I would guess that she may well have had some other coagulation defect which may have predisposed her to this tendency to bleed. Perhaps we should suspect some increased capillary fragility on the basis of recurrent infection but to my knowledge this picture does not fit in in any way with this leukoerythroblastic syndrome.

So I would conclude by saying that this girl had this syndrome of myelofibrosis and/or osteosclerosis with extramedullary hematopoiesis which was present in the spleen, liver, and possibly in the kidneys (where it does occur in approximately 10 per cent of the cases). I don't know what the background for this syndrome might have been. The commonest specific causes for it are healed diffuse tuberculosis or metastasizing cancer, neither of which could be diagnosed in our patient. So I am going to call it just idiopathic. Then I think that she had a severe upper and lower urinary tract infection with terminal sepsis, perhaps with many renal abscesses or severe necrotizing papillitis, which brought on renal failure. Finally I think that she had some terminal accident, either acute intra-abdominal hemorrhage or acute adrenal insufficiency, which was directly responsible for her sudden collapse and death.

Clinical Diagnosis

1. Leukoerythroblastic anemia.
2. Myelofibrosis with extramedullary hematopoiesis (idiopathic).
3. Severe urinary tract infection.
4. Sepsis.
5. Acute cardiovascular collapse due to:
   a. Adrenal insufficiency.
   b. Intra-abdominal hemorrhage.

Pathologic Diagnosis

1. Panmyelosis with myelofibrosis.
2. Severe urinary tract infection.
3. Sepsis.
4. Bilateral infarction of adrenals.

Pathologic Discussion

DR. VON HAAM: I want to congratulate Dr. Wilson for a very excellent discussion.

The autopsy showed that the patient was very anemic and rather emaciated, weighing only 100 pounds. There was no jaundice or cyanosis, and her skin showed no ecchymoses. She had pitting edema of all her extremities and the sacral region as one would expect in a patient with cardiovascular insufficiency. The abdominal cavity contained about 1000 cc. of clear, amber fluid, and each pleural cavity contained about 300 cc. The heart was small and showed no evidence of pathologic change. The lungs were edematous and slightly firmer than normal, but no tumor nodules or abscesses could be demonstrated. The spleen was absent. The liver weighed 4500 grams and showed many very fine (1 mm.) gray nodules. The gallbladder was normal. There was no evidence of gastrointestinal bleeding.

Both adrenals were involved in a hemorrhagic mass present in the retroperitoneal space. Both glands appeared destroyed by extensive hemorrhages. The kidneys were normal in size and showed an advanced pyelonephritis although not severe enough to produce renal insufficiency. The patient died with a blood urea nitrogen of 8 mg. and a creatinine of 0.7 mg. The brain was not examined. All her lymph nodes were small and discrete.

Microscopic Examination

The heart muscle was infiltrated with many types of immature white blood cells. All lung sections showed myeloid, erythroblastic and megakaryocytic elements forming dense nodular masses which simulated pneumonia. Many small vessels contained ante-mortem platelet thrombi. The surgically removed spleen was re-examined and showed a moderate myeloid metaplasia and marked evidence of hemolysis. The spleen contained several large recent infarcts.

Sections through the liver showed an enormous increase of myeloid, erythroblastic and megakaryocytic elements in the sinusoids of this organ. Megakaryocytes were especially numerous and seemed to pack the capillaries. The lymph nodes contained similar cells in the sinusoids, particularly large numbers of eosinophilic myelocytes and erythroblasts.

The picture seen in the kidneys was hard to differentiate between myelosis and acute inflammation. The chronic pyelonephritis was evident by the many colloid casts in the excretory tubules, but the inflammatory process was partially obscured by the many myeloid elements. Many megakaryocytes were enmeshed in the capillaries of the glomeruli.

The adrenal glands showed the change which Dr. Wilson predicted as the possible cause for her terminal acute catastrophe. The patient had many thrombi in smaller and larger vessels, and had a complete infarction of both adrenal glands. There seemed no doubt that the acute necrosis of both adrenal glands produced the symptoms of acute adrenal insufficiency which was responsible for her death.

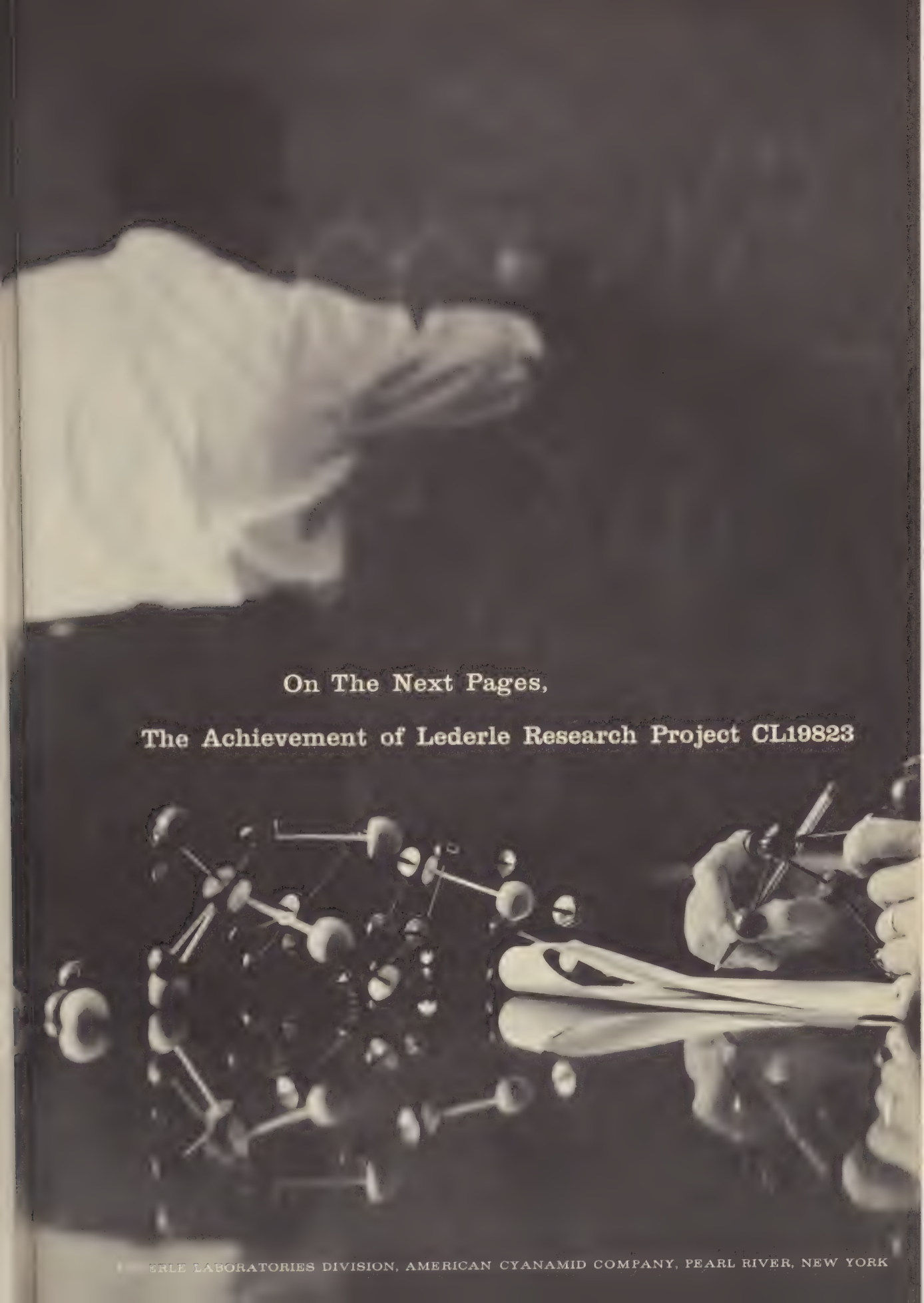
We did extensive bone marrow studies of many bones and they showed quite varying pictures. Some sections showed a bone marrow rich in cells and without any fibrosis, where the cell population was composed of a mixture of myeloid-erythroblastic elements which was either normal or hyperplastic. The bone spicules were rather thin and the marrow appeared exuberant. However, other areas of the skeleton, particularly the sternum, showed a great paucity of myeloid cells. Here the marrow contained a very fine network of young fibroblasts with myeloid cells present in reduced number in the fibrillar network. There was no evidence of osteosclerosis or marble bone disease, but rather the picture of myeloid fibrosis. No evidence of tuberculosis or tumor metastasis was present.

What is the disease process we are dealing with in this case? The name suggested for it by Black-Schaffer and Stoddard in 1953 is panmyelosis. According to these authors, panmyelosis is a disease in which a generalized proliferation of all cellular elements of the bone marrow occurs, including erythroblasts, myeloblasts, megakaryocytes, reticulocytes and even the fibroblasts. It can be differentiated from granulocytic or myeloid leukemia by several factors which Dr. Wilson has already emphasized. Histologically panmyelosis can be diagnosed by the presence of extramedullary hematopoiesis of all bone marrow cells beyond any compensatory replacement, even in cases without myelofibrosis. This patient had many more megakaryocytes in her liver alone than she lost by the fibrotic foci of her marrow. Even when myelofibrosis occurs, it is considered by the proponents of this theory not as evidence of a myelophthisic process but as evidence of proliferation of integral cellular components of the bone marrow, the fibroblasts.

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On The Next Pages,

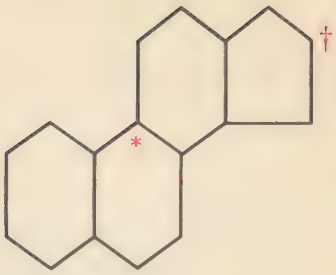
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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension—Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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Lederle

The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort

in Nephrotic Syndrome

Fourteen patients with the nephrotic syndrome have been treated with ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

Eleven patients with pulmonary emphysema and/or fibrosis were treated with ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

Forty-four children and adults have been given ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◊ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

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in Disseminated Lupus Erythematosus

◊ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

Medical Education Week . . .

Seek To Center Attention of Public on Ever-Increasing Contributions Of Medicine to the American Way of Life During Period of April 20-26

A NATIONWIDE salute to the medical schools of the country is being planned for the week of April 20-26, which has been designated as MEDICAL EDUCATION WEEK.

Co-sponsors are: American Medical Association; Association of American Medical Colleges; American Medical Education Foundation; National Fund for Medical Education; Student American Medical Association and the Woman's Auxiliary to the American Medical Association.

The general objective of the project is to focus the attention of the public on the ever-increasing contribution of medicine to American life and the basic significance of medical education.

County medical societies throughout the country have been furnished with comprehensive material including tips on community promotion, suggested newspaper releases, factual information on medical education and a radio and TV packet.

Suggested as part of community promotion are speeches to luncheon clubs and other organizations. Films are available for club showings.

The radio-TV packet includes spot announcements to be used during station breaks and a 30-minute script, to be adapted locally for radio or television.

To supplement radio and TV programs arranged locally, the National Medical Education Week Committee has sent packets of film clips, glass slides, spot announcements and other visual and written material directly to each radio and TV station throughout the country. The advertising Council, a national organization which publicizes service projects, has approved Medical Education Week, and an announcement to that effect will be carried in its March-April bulletin.

In his endorsement of Medical Education Week, President Eisenhower said: "In this great area of American Medicine, it is fitting that we set aside a special week each year to consider the work of our medical schools."

Officers of county medical societies in Ohio have been urged by Dr. Robert S. Martin, President of the Ohio State Medical Association, to cooperate in so far as practicable in the local observance of Medical Education Week. Mrs. Victor R. Frederick, President of the Woman's Auxiliary to the OSMA, has recommended to local auxiliaries that they offer their assistance to county medical societies in using the material which has been furnished for local promotion.

Dr. Martin also issued a news release to all Ohio newspapers, radio and TV stations announcing April 20-26 as Medical Education Week. Included was a statement on the significance of medical education; national data on medical schools, and data on the three Ohio medical schools, Ohio State, Western Reserve and Cincinnati, including the number of students, 1957 graduates and plans for expansion.

Conference on Solicitations in Cleveland, April 23-24

Current trends in the field of contributions will be the focal point of major addresses and discussions at the Fifth National Conference on Solicitations, to be held in Cleveland, April 23 and 24.

F. Emerson Andrews, director of the Foundation Library Center, New York City, and former director of philanthropic research at the Russell Sage Foundation, will deliver the keynote address—a review and analysis of contribution trends in the past year. Ralph H. Blanchard, executive director of United Community Funds and Councils of America, in a major speech, will discuss community chest trends. Dr. Norman P. Auburn, president of the University of Akron and immediate past president of the Council for Financial Aid to Education, will speak on present and future trends in corporate aid to education. Dr. Madison B. Brown, associate director of the American Hospital Association, will discuss the increasingly urgent subject of hospital needs and basis for support.

Three to four hundred registrants from commerce and industry and the professions are expected to be present. Physicians interested in this subject are invited.

The Conference advance registration fee of $45.00 includes all sessions, meals, social hours, banquet, and a copy of the proceedings. Reservations may be made by writing direct to the National Conference on Solicitations, Inc., 400 Union Commerce Bldg., Cleveland 14, Ohio.

metaphosphate produced markedly higher blood levels than capsules containing either the corresponding base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium metaphosphate, found [illegible]

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

[illegible] addendum to the last mentioned paper of [illegible]ch et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the presence of calcium as fillers in some of the capsules and not in others.

This, however, fails to explain the most recent findings of Welch and Wright,[10] who compared the absorption of three capsules, each containing 250 mg. of oxytetracycline hydrochloride — one without any adjuvant, one with 250 mg. of citric acid and the third with 380 mg. of sodium hexametaphosphate; no other filler was contained in any of these capsules. In triple

[illegible] and of sodium metaphosphate were published simultaneously with the last mentioned report of Welch et al.[7] These data were based on thoroughly controlled studies both in rats[8] and in man[9] and include additional findings that serve to explain, fairly conclusively, the various discrepancies that have been mentioned.

The experiments in rats[8] were carried out to study the effects of citric acid, dicalcium phosphate, sodium metaphosphate, food, oil and sorbitol on the serum antibacterial activity produced by the administration of tetracycline hydrochloride or tetracycline base. Citric acid administered in equal weight with tetracycline hydrochloride gave the highest concentrations of all the preparations studied. No enhancing effect was obtained from citric acid when given with tetracycline base. Dicalcium phosphate and food resulted in lower, and sodium metaphosphate in higher, serum antibacterial activity than was observed in their absence. Oil and sorbitol did not interfere with tetracycline absorption.

Dicalcium phosphate is widely used as a filler in various capsules, including those of the tetracyclines. The authors cite a large number of other studies that implicate the presence of calcium ions as the cause of the reduced absorption of tetracyclines and show that citric acid can partially neutralize this effect. The depressing effect of food on the serum levels of tetracycline is likewise explained by the goodly amount of minerals contained in commercial laboratory diets, and they postulate that the multivalent cations may be responsible for the poorer absorption of the drug. The authors could not explain the failure of citric acid to enhance serum concentrations when administered with tetracycline base in contrast to its marked effect when given as the hydrochloride. However, they hypothesized that the ability of citric acid to enhance serum levels of tetracycline is related to its ability to form complexes [illegible] unavailable for

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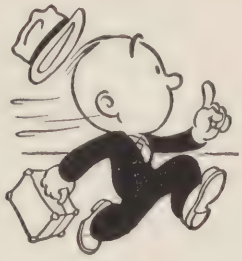
TETRACYCLINE HCl BUFFERED WITH CITRIC ACID

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Lederle

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK
*Reg. U. S. Pat. Off.



Hotel Reservation!

For the 1958 Annual Meeting
Ohio State Medical Association
April 15, 16, and 17 — Cincinnati

It's a bit late, but worth trying if you haven't already made your hotel reservations. Best policy for late reservations is to phone or wire the hotel of your choice. Here are some leading downtown Cincinnati Hotels:

NAME OF HOTEL	SINGLE	DOUBLE	DOUBLE TWIN BEDS
NETHERLAND HILTON HOTEL, Fifth & Race Sts.	$ 7.00-11.50	$12.50-15.50	$13.00-21.00
BROADWAY HOTEL, Fourth & Broadway	$ 4.50- 7.00	$ 7.00- 9.50	$10.00-15.00
METROPOLE HOTEL, 609 WALNUT ST.	$ 5.50- 8.50	$ 8.50-12.00	$ 9.50-15.00
SHERATON-GIBSON HOTEL, 42 Walnut St.	$ 5.85-13.00	$ 9.85-16.00	$11.00-17.50
SINTON HOTEL, Fourth & Vine Sts.	$ 6.00-11.50	$ 9.00-13.50	$11.50-14.50
TERRACE HILTON HOTEL, 15 West 6th St.	$12.00-18.00		$16.00-22.00

Persons who desire suites or other additional accommodations are advised to specify their needs to the hotel of choice.
(All rates subject to change)

HOTEL RESERVATION BLANK
Mail the coupon to hotel selected

Manager .....Hotel, Cincinnati, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 15, 16, 17, 1958, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price.....

☐ Twin Bed Room with Bath ☐ Additional Accommodations (Specify)

Arriving April..... at..... A.M.....P.M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

A Quick Checklist on the . . .

1958 Annual Meeting, Ohio State Medical Association, The Netherland Hilton Hotel—Cincinnati—April 15, 16 and 17.

√ Have You Made Arrangements To Attend?

Refer to the March issue of *The Journal* in which the complete program is printed. In that issue are details of Specialty Section programs, other scientific and clinical discussions, Specialty Society programs, Scientific and Educational Exhibits, Technical Exhibits, sessions of the House of Delegates, alumni and other organization get-togethers.

√ Have You Ordered Your Annual Banquet Tickets?

This is the featured social event of the Annual Meeting. The time is Wednesday, April 16, beginning at 7:30 p. m. You can get tickets at Reservation Headquarters, Netherland Hilton. The charge is $7.50 per plate. The price includes tips and tax and will cover cost of dinner, an evening of entertainment and dancing.

√ Have You Made Your Hotel Reservations?

If not, the facing page gives you information on this subject. Better phone the hotel of your choice and make arrangements.

Make It a Date with Your Colleagues:

The 1958 Annual Meeting — Cincinnati — April 15, 16 and 17

Proceedings of The Council . . .

Heavy Docket Considered at March 1 Meeting; Matters Relative To VA Medical Program; Medicare; Ohio Medical Indemnity Acted Upon

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the Columbus office on Saturday afternoon and evening, March 1, 1958. All members of The Council were present. Also present were the following: Dr. Charles L. Hudson, Cleveland, Past-President and chairman of the Committee on Medical Services; Mr. John Eastman, Toledo, representing Mr. Wayne E. Stichter, legal counsel, who was unable to attend because of illness; Mr. Charles H. Coghlan, Executive Vice-President of Ohio Medical Indemnity, Inc., and Messrs. Nelson, Saville, Page, Edgar and Moore.

By official action, the minutes of the meeting held on December 14 and 15 **were approved.**

The Executive Secretary reported on membership as follows: Number of members of the OSMA as of March 1, 1958, 7,700, of which 6,860 have affiliated with the AMA.

Actions on By-Laws

Action was taken as follows on revisions adopted by certain County Medical Societies in their constitution and by-laws:

New constitutions and by-laws adopted by the Gallia County Medical Society and the Ottawa County Medical Society **were approved** as submitted.

Revised constitutions and by-laws submitted by the Coshocton County Medical Society and by the Van Wert County Medical Society **were approved**, providing such societies make slight changes in the wording in order to bring such documents into conformity with the OSMA Constitution and By-Laws.

Amendments adopted by the Toledo Academy of Medicine on January 15, 1958, **were approved** as submitted.

Action was deferred on a revised constitution and by-laws submitted by the Wayne County Medical Society due to the fact that certain provisions were in conflict with the OSMA Constitution and By-Laws.

A communication from the Summit County Medical Society, asking certain questions about the possibility of adoption of a code of regulations to govern activities other than those covered by the by-laws of the society, **was referred** to legal counsel for study and advice.

Auxiliary By-Laws

A set of proposed amendments to the Constitution and By-Laws of the Woman's Auxiliary to the Ohio State Medical Association, to be voted on at the April meeting of the Auxiliary, was reviewed by The Council as required by the Constitution and By-Laws of the Auxiliary. By official action, The Council **approved** all of the proposed amendments except suggested amendments to Chapter 5 of the By-Laws of the Auxiliary relating to the filling of vacancies in office. The proposed amendments which received Council approval may be submitted by the Auxiliary to the 1958 meeting for action.

Committee on Medical Services

The Council received a report from Dr. Charles L. Hudson, chairman of the Committee on Medical Services, with regard to a meeting of that committee on Wednesday, January 29, which meeting was attended by representatives of the State Welfare Department and Division of Aid for the Aged. By official action, The Council **approved** the report of the committee on that meeting.

V. A. Medical Care Plan

The Council considered a communication from the Veterans Administration suggesting that the Association might wish to discontinue its formal contractural agreement covering hometown care of veterans.

By official action, **The Council voted** that the formal contract with the Veterans Administration **should be discontinued** at the end of the present fiscal year, namely, June 30, 1958.

By official action, The Council **instructed** the Committee on Medical Services to confer with the Veterans Administration with regard to changes in the schedule of allowances for medical services in Ohio. Specifically, The Council suggested to the committee that it work out with the V. A. a schedule of allowances which would be a combination of the current schedule and the national Guide for Charges for Medical Services, M-1, Appendix A, V. A. Catalog No. 5.

Medicare

Communications from General Robinson, Executive Director, Office for Dependents Medical Care,

Washington, were reviewed. These communications asked whether or not the Association would consider entering into a contractural relationship with the Government on the Medicare program during the coming fiscal year starting July 1, 1958, and requested the Association to send representatives to Washington to confer with the Medicare officials on a revised schedule of allowances for Medicare services in Ohio.

After an extensive discussion of this subject; a review of the previous policy of the Association on the Medicare program; and an analysis of the Medicare activities in Ohio during the past year, The Council, by official action, **adopted** the following as an official reply from the Ohio State Medical Association to General Robinson on the matters covered in his communications to the Association:

"The Council of the Ohio State Medical Association on March 1, 1958, gave careful consideration to your letters of November 27 and December 13, 1957, and to the revised Medicare Manual which accompanied your letter of December 13.

"By official action, The Council reaffirmed the policy of the Ohio State Medical Association on the Medicare Program, adopted on November 11, 1956.

"As you know, that policy precludes the Association from entering into contractual arrangements with the Government on Medicare matters because of a difference of opinion between the Government and the Ohio State Medical Association on certain basic principles which were enumerated in the statement of policy.

"Your letter of November 27 stated your records indicate that about 20 per cent of the physicians of Ohio have been participating in the Medicare Program and that your relationship with them has been satisfactory.

"This would indicate that the schedule of allowances which you used in 1957 in Ohio should be maintained during 1958 and that allowances for **new items** should be established by your department at comparable amounts.

"On the matter of setting up separate allowances where surgery is performed by one physician and the aftercare supplied by another, The Council respectfully points out that it is customary in Ohio for the physicians involved in flat-allowance cases to decide how much of the total maximum allowance each is entitled to, based on the extent of the services rendered, and for each physician to submit his own separate bill for the amount agreed upon. The Council believes that this policy should be followed in administering the Medicare Program in Ohio.

"The Council suggests that the policies and procedures applying to anesthesia and assistants be continued as set forth in the current Ohio Manual.

"In conclusion, The Council again respectfully urges your department and your superiors to revise the Medicare rules and regulations to permit operation of the program on an indemnity basis where desired."

Atlanta Meeting

Dr. Hudson presented a report on a meeting in Atlanta, Georgia, on January 11 and 12, 1958, attended by representatives of about a dozen medical associations for the purpose of discussing ways to get the Government to allow the Medicare program to operate as an indemnity-type plan. Dr. Hudson had been sent to the meeting as an official representative of the OSMA. He read to The Council the following recommendation of the Atlanta conference:

"The representatives of state medical associations meeting in Atlanta, Georgia, January 11-12, 1958, to consider Medicare object to the administrative regulations of the program.

"Specifically, they take exception to the imposition of a service-type program, because of their convictions that under P. L. 569 an indemnity-type plan is permissible. Further they express their sincere belief that an imposed service-type program interferes in principle and in practice with the doctor-patient relationship and contributes to deterioration of good medical practice.

"They consider it imperative for these and other state associations jointly to petition the appropriate congressional committees and the Secretary of Defense to permit negotiation of an indemnity program at the time of renewal of Medicare contracts.

"They therefore agree to request their associations to petition the appropriate congressional committees and the Secretary of Defense in this regard, in a concerted action, at the earliest moment permitted by approval of the associations concerned."

A letter dated February 24 from the Medical Association of Georgia, asking what action the Ohio State Medical Association had taken on the Atlanta recommendations, was discussed. After a thorough discussion, **The Council, by official action,** stated that while it was in agreement with the recommendation of the Atlanta conference that follow-up action with respect to the indemnity matter should be taken, The Council felt that the best follow-up procedure at this time would be for the interested states to officially request the Board of Trustees of the AMA to take more forceful action with the Government in an effort to have the Medicare regulations amended, or the law itself changed, to permit the Medicare program to operate as an indemnity-type plan in areas where this is desired. It was the belief of The Council that it would be much more effective to have the educational follow-up activities carried on by the AMA than by a relatively few state societies.

OASI Program

The Executive Secretary submitted a report on a conference he had held with representatives of the OASI disability section of the Bureau of Vocational Rehabilitation with regard to fees paid for examinations made by internists at the request of the Bureau. He pointed out that an increase has been made in the fee from $15.00 to $20.00 and that a revised letter is now being sent to internists, pointing out that additonal fees are paid for diagnostic evaluation tests which are required in addition to the history, physical examination and report.

The Executive Secretary was instructed to convey this information to the Ohio Society of Internal Medicine to ascertain whether or not this

meets the questions which that society had raised regarding the fees and procedure.

Third-Party Programs

There was a general discussion of questions relating to third-party medical care programs, including comments by Dr. Hudson and a report by Mr. Saville on the recent meeting of the AMA Public Relations Advisory Committee of which he is a member, at which meeting the question of an educational program on this subject was discussed. It was generally agreed that a general educational program on third-party medical care plans is desirable but that how such programs should be carried on needs very thorough study. It was agreed that the OSMA should not proceed with anything definite until the AMA has had an opportunity to draft some tangible recommendations for consideration. The matter was left in the hands of the Committee on Medical Services for study and future action.

Annual Meeting

The Executive Secretary reported on arrangements for the 1958 Annual Meeting in Cincinnati, April 15, 16, 17.

Ohio Medical Indemnity

The Council received a report on a conference held in the Columbus office of the OSMA on January 12, at which the subject of inclusion of diagnostic x-ray and laboratory procedures in the Ohio Medical Indemnity schedule of indemnities was discussed. The meeting was attended by representatives of the Ohio State Medical Association, Ohio Medical Indemnity, Inc., Ohio State Radiological Society and the Ohio Society of Pathologists. In discussing the report, Mr. Coghlan, Executive Vice-President of OMI, pointed out that a committee of OMI has scheduled a series of conferences with representatives of the radiologists and pathologists to give further consideration to this matter.

Northeast Blue Cross

Mr. Coghlan reported on negotiations which are taking place between OMI and the Northeast Ohio Blue Cross organization with regard to continuing a working relationship in the Akron area. He pointed out that the Akron Blue Cross plan had been absorbed by the new organization and that this necessitated a revamping of the working arrangements.

Board Members Nominated

A nominating committee consisting of Drs. Woodhouse, Artman and Hamwi presented a report recommending nominees for the Board of Directors of Ohio Medical Indemnity to be voted on at the annual stockholders' meeting, April 23, 1958.

The committee reported to Council that Dr. Sherburne, Columbus, Dr. Mundy, Toledo, and Dr. Allison, Akron, who have served faithfully and competently on the OMI Board and have been very valuable members of the Board, have requested that their names not be presented for renomination and re-election. The committee reported that it reluctantly **recommends** to The Council that the wishes of the three physicians be complied with and that in taking this action The Council commend and thank them for their excellent contribution to the conduct of the business of Ohio Medical Indemnity.

The committee **placed in nomination** the following to succeed Drs. Sherburne, Mundy and Allison: Dr. Perry R. Ayres, Columbus; Dr. Gordon M. Todd, Toledo, and Dr. Robert S. Martin, Zanesville. By official action, The Council **approved** the nominations and ordered that such names be presented to the stockholders of Ohio Medical Indemnity for action on April 23.

The committee **recommended** that the following members of the OMI Board be renominated: Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; Mr. D. A. Endres, Youngstown; Dr. D. W. English, Lima; Mr. Clair E. Fultz, Columbus; Dr. Charles N. Hoyt, Chillicothe; Mr. Fred D. Learey, Columbus; Msgr. Robert A. Maher, Toledo; Dr. J. Stewart Mathews, Cincinnati; Mr. Richard M. Ross, Columbus; Dr. George L. Sackett, Cleveland; Dr. L. Howard Schriver, Cincinnati; Mr. Harold W. Slabaugh, Akron; Dr. Robert G. Smith, Circleville; Mr. David L. Temple, Dayton; Mr. James V. Walker, Columbus; Dr. Edmond K. Yantes, Wilmington; Dr. Starling C. Yinger, Springfield.

By official action, The Council **approved** this recommendation and ordered these names submitted to the stockholders for action.

On recommendation of the committee and by official action, The Council **authorized** the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI on April 23, 1958, on all business matters coming before that meeting, including the election of directors placed in nomination by The Council at its meeting on March 1, 1958: Dr. H. M. Clodfelter, Columbus, or Dr. Edmond K. Yantes, Wilmington, or Mr. Charles S. Nelson, Columbus.

Medical Assistants

Dr. Petznick reported on a conference held in the Columbus office on January 25 attended by

himself and Dr. Orr, two members of the special committee of the OSMA on Medical Assistants, and by representatives of the Ohio State Society of Medical Assistants for the purpose of working out suggested changes in the constitution and by-laws of the Ohio State Society of Medical Assistants. He stated that the matter is now in the hands of the medical assistants group and that further consideration by The Council would not be required until some agreement has been reached by that organization on the constitution and by-laws and on other organization matters.

Student Lectures

Drs. Mayfield and Artman presented reports on the lectures for medical students given at the University of Cincinnati and Ohio State University. A statistical report was presented by Mr. Edgar regarding attendance. It was agreed that the one-day plan for the lectures was a definite improvement over the plan of past years and that the one-day plan should be continued. Mr. Edgar reported that the lectures will start at Western Reserve University during the week of March 3.

Salk Polio Vaccine Ad

The Council **authorized** the running of an advertisement from the Public Relations Department of the AMA on Salk vaccine reminder cards in an early issue of *The Journal.*

Malpractice

A communication from the American Medical Association, requesting the Association to take part in the formation of a joint medical and hospital liaison committee on a state level for the purpose of discussing professional liability matters, was **deferred** for further consideration.

C-3 Claims

The Executive Secretary reported on conferences held with the administrator of the Bureau of Workmen's Compensation on the matter of endeavoring to have the numbers of C-3 claims sent to physicians. He advised The Council in detail of reasons set forth by the Bureau as to why this could not be done. The Council **agreed** that the arguments presented by the Bureau are reasonable and that these reasons could be cited to any individual member inquiring about this particular subject.

Federal Legislation

The status of Federal legislation, including the Forand Bill and the Jenkins-Keogh Bill, was discussed briefly. It was pointed out that Dr. Howard of the AMA would comment on these matters at the County Society Officers Conference on March 2.

AMEF Figures for 1957

Reporting for Dr. Merrill D. Prugh, Ohio chairman for the American Medical Education Foundation, Mr. Saville stated that Ohio's contribution to AMEF in 1957 was a record-breaking $33,141.87 from 717 donors. Comparable figures for 1956 were: $27,724.78 from 587 contributors. The amount contributed by medical alumni directly to their own schools in 1957 is not yet available. In 1956, such contributions numbered 2,535 for a total of $113,527.92.

Medical Education Week

On recommendation of Mr. Saville, The Council **approved** the following outline of activities of the OSMA with regard to participation in medical education week, April 20-26, 1958:

1. **News release** to newspapers, radio and TV stations, quoting Dr. Martin as President. This would include:
   (a) Statement on significance of medical education.
   (b) National data on medical schools.
   (c) Data on 3 Ohio schools, showing number of students, 1957 graduates and plans for expansion.

2. **Bulletin to all county medical societies** urging them to utilize, where practicable, promotional material mailed to them direct by AMA. This material will include:
   (a) Community promotion packet.
   (b) Radio and television packet.
   (c) Newspaper packet.

Among the material to be furnished are: Fact sheets for the use of luncheon club speakers; lists of films available for club showings; spot announcements for radio and TV; and other promotional tips designed to arouse community interest in Medical Education Week.

3. **Special Bulletin** to academies of medicine in Cleveland, Columbus, and Cincinnati, urging their cooperation with the three medical schools on local radio and TV programs.

4. **Communication to state officers of Woman's Auxiliary** to O. S. M. A. urging them to recommend to local auxiliaries that they offer their assistance to county medical societies in the local promotion of Medical Education Week.

Traffic Safety Conference

The President was **authorized** to select an official representative from the Association to the National Conference on Traffic Safety, Sherman Hotel, Chicago, April 1-2. Dr. Martin requested

Dr. Woodhouse, the President-Elect, to make this selection and work out the details.

Lung Cancer Study

The Council **approved** a study of lung cancer deaths by the National Cancer Institute and the National Office of Vital Statistics in cooperation with the various State Health Departments, including the Ohio Department of Health, using death certificates and information obtained from the relatives of decedents as to the smoking habits of such decedents.

Future Planning Committee

Dr. Meiling reported, as follows, for the Committee on Future Planning:

"The Preston Cook Real Estate Company of Columbus, Ohio, has informed this committee that the property located at the southwest corner of East Broad Street and Sixth Street is for sale and might well be considered for the site of the future home of the OSMA. This property is currently in use as a parking lot and the asking price is $135,000.00.

"This property is as close to the center of the City of Columbus as is apt to be available in the next several years. It has a frontage on both Broad and Sixth Streets and there is a paved alley across the southern most boundary of this property which is approximately 180x250 feet.

"The committee awaits the suggestions of The Council re the further investigation of this real estate or other as it may become available."

By official action, The Council **instructed** the committee to make further investigation of this particular piece of property and any other properties which might be brought to their attention.

The Council **instructed** the Executive Secretary to send a message to Mr. Stichter, expressing the hope for his immediate recovery from the illness which prevented him from attending this meeting.

The Council then adjourned.

Attest: CHARLES S. NELSON,
Executive Secretary.

New Business Manager Is Appointed

Mr. Russell H. Clark, formerly staff assistant to the vice-president and general manager of the Chicago Tribune Company, has been formally appointed business manager, with all AMA business activities under his supervision.

Thomas R. Gardiner, with 48 years with the AMA, is giving up his full-time business manager position to become consultant on advertising and technical exhibits. He joined the AMA April 2, 1909, and has played an important role in the tremendous growth of AMA business activities.

Northern Tri-State Association Announces Program May 8

The Northern Tri-State Medical Association, composed of physicians of the adjoining areas of Ohio, Michigan and Indiana, has announced its annual program to be held Thursday, May 8. Place is the Morris Inn, University of Notre Dame Campus, South Bend, Ind. The program has been announced as follows:

(Central Daylight Saving Time)

8:00 Registration.

9:00 Welcome. R. A. Fargher, M. D., President; Keith E. Selby, M. D., President of St. Joseph County Medical Society.

9:15 "**Dynamics of Geriatrics,**" C. Howard Ross, M. D., Ann Arbor, Mich.

10:00 "**Fever of Undetermined Origin,**" Frank J. Heck, M. D., Mayo Clinic.

10:45 "**What You Can Do with Your Money —If You Have Any?**" Don Juan Fernandez, of Merrill, Lynch, Pierce, Fenner & Smith, Chicago, Ill.

11:30 Social Hour, Courtesy of Wayne Pharmacal Co.

12:00 Luncheon at Morris Inn.

A. Invocation, Rev. Philip S. Moore, C.S.C., Vice-President, Academic Affairs, Univ. of Notre Dame.

B. Remarks, Kenneth Olson, M. D., President-Elect, Indiana State Medical Association, South Bend, Indiana.

C. Address: "**Medical-Public Responsibility,**" by The Honorable G. Mennen Williams, Governor of the State of Michigan.

D. Short Business Meeting.

2:00 "**What's the Use of God?**" Rev. Calvin W. Didier, Presbyterian Church, La Porte, Indiana. (This should be of interest to both doctors and their wives.)

2:45 "**The Anticoagulants—Where Are We Now ?**" Karl Paul Link, Ph. D., Univ. of Wisconsin. (Recently given the Lasker Award for the discovery of Dicumarol.)

3:00 "**Gynechiatry,**" William B. Keller, M. D., Louisville Kentucky General Hospital.

Entertainment for the ladies has been arranged for the afternoon.

Registration and dues amount to $5.00. An additional fee of $5.00 per person should be included for luncheon. Registration accompanied by check may be mailed to: Charles M. Burgess, M. D., 23235 Woodward Ave., Ferndale 20, Mich.

QUESTIONS FOR CONSIDERATION BY OSMA HOUSE OF DELEGATES IN CINCINNATI

AMONG the questions which will be considered by the House of Delegates of the Ohio State Medical Association at the 1958 Annual Meeting, April 15, 16 and 17, Cincinnati, are the following proposed resolutions. These were submitted to the Columbus Office in time for publication in the April issue of *The Journal*. Other resolutions, no doubt, will be presented at the first session of the House of Delegates on Monday evening, April 14.

Resolution No. 1

This resolution will be submitted on behalf of the Coshocton County Medical Society:

WHEREAS, There has arisen a problem to the physicians of Ohio relative to their status in regards to payment for their services to certain individuals covered by third-party payment plans and,

WHEREAS, The principle of indemnity payments has been repeatedly endorsed by the House of Delegates of the Ohio State Medical Association and the Council of the Ohio State Medical Association and,

WHEREAS, The House of Delegates of the Ohio State Medical Association by action at the Annual Meeting in 1956 affirmed that it was not the province of a third-party to qualify any physician as to his ability or professional standing and,

WHEREAS, Certain third-party groups, notably the Welfare and Retirement Fund of the United Mineworkers of America, have restricted their payments to individuals and hospitals selected by the third-party without the recipient of the services having any voice in such selection and,

WHEREAS, Such action as detailed in the paragraph next above prohibits many qualified physicians and hospitals from rendering care to individuals entitled to care under such plans and, more importantly, tends to lower the quality and availability of medical care to which such individuals are entitled,

THEREFORE BE IT RESOLVED, That this House of Delegates suggest that a plan be evolved whereby the third-party deal directly with the recipient of any benefits and that the beneficiary deal directly with the physician or hospital involved and,

That such a plan be effective for any legally licensed physician in Ohio and any hospital accredited by the Joint Commission on Accreditation of Hospitals and,

That a copy of this resolution be sent to Dr. Warren Draper, Administrator of the Welfare and Retirement Fund of the United Mineworkers of America, with a request that he consider it and make reply and comments to our President, Dr. George Woodhouse, 79 East State St., Columbus, Ohio.

Resolution No. 2

Resolution No. 2 will be submitted by Dr. Charles W. Pavey, delegate from Franklin County:

WHEREAS, The Ohio State Medical Association has for several years endorsed the Essay Contest for High School Students, of the Association of American Physicians and Surgeons (Titles: The Advantages of Private Medical Care or The Advantages of The American System of Free Enterprise) and

WHEREAS, The need for such a contest seems to increase each year and

WHEREAS, This contest has received increasing sponsorship throughout Ohio by the Auxiliaries of the County Medical Societies and

WHEREAS, Such approval by the House of Delegates of the Ohio State Medical Association is essential to the continuing sponsorship by the State and local auxiliaries

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association for 1958 go on record as approving this contest and recommending it to the Woman's Auxiliary for sponsorship.

Resolutions No. 3, 4 and 5

Resolutions No. 3, 4 and 5 will be presented by the delegates of the Academy of Medicine of Cincinnati and Hamilton County:

Resolution No. 3

WHEREAS, The Ohio State Medical Association deemed it necessary to adopt and promulgate a policy regarding the determination of the ethical status of physicians participating in third party medical plans, and

WHEREAS, Local county medical societies may be compelled to use the policy presented before governmental agencies and courts of law, and

WHEREAS, The general principle of free choice of a physician by a patient has been upheld by the Ohio State Medical Association and the American Medical Association,

THEREFORE BE IT RESOLVED, That the words "a reasonable degree of" be deleted from conclusions and recommendations on page 12, paragraph 2 (e), of the Statement of Policy, thereby causing paragraph 2 (e) to read "Deny to the members of the community in which the physician practices, free choice of a physician or physicians."

Resolution No. 4

WHEREAS, The Division of Aid For The Aged, Department of Public Welfare, is experiencing difficulty in administering its medical program, and

WHEREAS, This program has received widespread criticism, and

WHEREAS, The medical profession is desirous of assisting this agency of the State of Ohio to function in an efficient manner,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association offer the services of a committee to deliberate with the Division of Aid For The Aged, Department of Welfare of the State of Ohio, and to propose the formation of a sound, equitable, and workable program, including a recommendation for the adoption of an adequate medical fee schedule.

Resolution No. 5

WHEREAS, The present Constitution and Bylaws of the Ohio State Medical Association, Chapter II, Section I, specify that a Doctor of Medicine must be retired from the active practice of medicine to be eligible for exemption of annual dues, and

WHEREAS, It is felt that a member in good standing of this Society, who has attained the age of seventy (70) years, should be eligible for exemption from the annual dues of this Society regardless as to whether or not he is engaged in the active practice of medicine,

THEREFORE BE IT RESOLVED, That Chapter II, Section I, of the Bylaws of the Ohio State Medical Association be amended by the insertion of a third paragraph to read as follows:

"Provided also that a Doctor of Medicine who is a

member in good standing of this Association, at the time of his attainment of the age of seventy (70) years, shall be exempt from the payment of dues and assessments in this Association, provided he requests such exemption and such request is approved, in writing, by the Secretary-Treasurer of his component Society."

Resolution No. 6

Resolution No. 6 will be presented on behalf of the Wood County Medical Society. It reads as follows:

WHEREAS, In order to produce, process and preserve foodstuffs for human consumption, it is necessary to bring into the State of Ohio migrant laborers; and

WHEREAS, These people do not reside in the State of Ohio or the various counties of the state long enough to become legal residents; and

WHEREAS, They need, from time to time, medical care rendered by physicians and hospitals of Ohio; and

WHEREAS, They often do not, on their own volition, reimburse the said physicians or hospitals for medical care,

BE IT RESOLVED, That by law, all migrant laborers and their dependents be insured to cover the cost of medical care while in the State of Ohio; and

BE IT FURTHER RESOLVED, That all employers of migrant labor be required by law to ascertain that such insurance is available, in lieu thereof, be responsible for all medical care of migrant laborers and their dependents; and that every possible means be used to make this the law of the State of Ohio.

New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since January 2, 1958. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

Ashtabula County
Karlis N. Pope, Andover

Athens County
Izak L. Weber, Coolville

Belmont County
Heinz Lord, Barnesville

Butler County
Peter A. Ammentrop, Middletown
Robert P. Johnson, Middletown

Crawford County
Robert D. Myers, Crestline

Cuyahoga County
Alexander L. Herland, Cleveland
Stanley Hrynkiewich, Cleveland
Sidney King, Cleveland
John R. Judge, Cleveland
Louis Rakita, Cleveland
John W. Russell, Cleveland

Darke County
Charles E. Gariety, Greenville

Delaware County
Robert W. Brannon, Delaware

Erie County
Mario Tamburini, Sandusky
Sigismund Vechey, Sandusky

Franklin County
Richard W. Booth, Columbus
Roy L. Donnerberg, Columbus
Daniel W. Elliott, Columbus
Edwin B. Hamilton, Columbus
W. Beale Lutz, Columbus
Dale H. Magleby, Columbus
Jack Marks, Columbus
Isadore Mendel, Columbus
Thomas K. Oliver, Columbus
Mark Panitch, Columbus
Malcolm L. Robbins, Columbus

Fulton County
Donald A. Stotzer, Archbold

Gallia County
Odell C. Kimbrell, Jr. Gallipolis

Greene County
Quinten L. Erd, Jamestown
Richard A. Falls, Xenia
John L. Wolff, Xenia

(Continued Next Column)

(New Members of OSMA—Continued)

Guernsey County
L. John Albuquerque Cambridge

Hamilton County
Marcus B. Bond, Cincinnati
Raul Florez, Cincinnati
Alvin Friedman, Cincinnati
Nell K. Levy, Cincinnati
Thomas L. Jones, Cincinnati
Janus C. Lindner, Cincinnati
James F. Stewart, Cincinnati

Hardin County
Jack C. Lindsey, Kenton

Huron County
Wilfred B. Dodgson, Norwalk
William B. Holman, Norwalk

Lawrence County
Dean F. Massie, Ironton

Logan County
John J. Roget, Belle Center

Lorain County
Arnold Windt, Elyria

Lucas County
Joan M. Baumgartner, Toldeo
Theodore F. Haase, Toledo
Hendrik Vannak, Toledo

Mahoning County
William H. Bunn, Jr., Youngstown
Maria J. Colucci, Petersburg
Jordan Dentscheff, Youngstown
Frederick W. Dunlea, Youngstown
Henry Holden, Youngstown
John P. Kalfas, Youngstown
Arthur T. Laird, Youngstown
James A. Quinn, Jr., Youngstown
Roy L. Thomas, Jr., Youngstown
Robert A. Wiltsie, Youngstown

Mercer County
Gunter A. Lamm, Mendon

Montgomery County
James D. Ruffner, Miamisburg

Muskingum County
Rolland D. Batemen, Jr., Zanesville
Myron H. Powelson, Zanesville

Perry County
Yu Ru Yuan, New Lexington

Richland County
Richard B. Belt, Mansfield
George D. Finlayson, Mansfield

Sandusky County
James C. Trivett, Fremont

Stark County
Andreas S. Ahbel, Canton
Robert B. Bird, Canton
John D. Botti, Canton
William R. Bush, Canton
Heinrich A. Gesenhues, Louisville
Joseph H. Iwano, Alliance
Daniel A. Kibler, Alliance
Zvonimir J. Mihanovic, Hartville
Bohdan Y. Panasuik, Waynesburg
Ralph L. Rutledge, Jr., Alliance
Hubert C. Swartout, Massillon
William G. Wasson, Canton

Summit County
Adolph Baltrukenas, Akron
Kenneth A. Del Greco, Barberton
James R. Hodge, Akron
Evelyn Lavery, Akron
Joseph S. Lichty, Akron
John T. Poulson, Akron
Richard D. Smith, Akron
Richard J. Yoder, Barberton

Trumbull County
Paul W. Pifer, Warren

Wyandot County
Konstantine K. Solacoff, Upper Sandusky

AMA and Science Writers Sponsor Series on Medical Writing

The American Medical Association and the National Association of Science Writers are jointly sponsoring a series of seminars or workshops in medical writing for newspaper reporters. The first of these conferences will be held at the Hotel Syracuse, Syracuse, N. Y., on Thursday and Friday, April 17-18.

Invitations are being mailed to editors of daily newspapers within a 300-mile radius of Syracuse, asking them to send one of their reporters to the meeting. County medical societies in the same area are also being invited to send a public relations representative.

The real purpose of the conferences, which will be held in various sections of the country, is to reach those newspaper writers who work on medical assignments but also handle other duties.

The two-day program in each geographic area undoubtedly will help develop better medical and science reporting at the local level.

Hospital Questions . . .

Answers to Some of the Problems of Hospitals and Hospital Staffs Prepared by Dr. Babcock, Director, Commission on Accreditation

MONTHLY the magazine *Hospitals,* official publication of the American Hospital Association, has been carrying questions and answers prepared by Dr. Kenneth B. Babcock, director, Joint Commission on Hospital Accreditation.

Following are selections from some of the questions and answers which have appeared in *Hospitals.* Additional material will appear from time to time in *The Journal.*

* * *

In our hospital we find patients bringing in medications on advice of their physician and self-medicating themselves. Is this allowable? If not, how do we stop it?

It is not allowable and should not be condoned. Hospitals usually have a ruling forbidding self-medication by patients in their medical staff by-laws, rules and regulations. These staff rules should be called to the attention of physicians who abuse it.

In their nursing service procedures many hospitals request the nurse admitting the patient to ask the patient if he has any medications on him and to give them up. If they are prescribed in the doctor's written order, they may be utilized. Even under these circumstances great care in proper identification must be utilized and the practice is frowned upon and forbidden in some hospitals.

* * *

In the August 1957 Bulletin of the Joint Commission on Accreditation of Hospitals, it states under x-ray department (I-b) that "a special sheet should be included in all hospital and clinical charts for data of fluoroscopic examinations, specifying data, site, roentgens per minute, exposure time and operator." Will it be satisfactory if this information is included on the regular x-ray report which is attached to the chart?

The procedure is perfectly acceptable and unquestionably will save time, effort and possibly filing space. Several hospitals are already following that procedure by having the information printed in a corner of the report. Where stationery was already printed, one hospital we know of had a rubber stamp made up and used it on their existing stationery.

Is it allowable to use a trained lay person, in our instance a former medical corpsman, as an anesthetist?

No—under no circumstances. A hospital should never allow anyone but a physician anesthetist or a registered nurse anesthetist to give anesthetics in the hospital.

* * *

Our hospital has two operating rooms in charge of an excellent licensed practical nurse. 1. Is this allowable? 2. May she scrub? 3. May she act as circulating nurse?

1. No, it is not allowable as far as the Joint Commission is concerned. Also, check your state law as far as your nurse practice act is concerned.

2. As far as the Joint Commission is concerned, a practical nurse or trained nurse aide may act as a scrub nurse, if she is under the direct supervision of a licensed graduate nurse. Again, check the nurse practice law in your state for safety and surety sake.

3. No, a licensed practical nurse may not act as a circulating nurse, for the same reasons given in the first part of this answer.

* * *

Should the consent for autopsy be kept on the chart or should the pathologist keep it in his files?

Preferably the consent for autopsy should be kept on the chart and usually is, but every hospital should have a definite fool-proof procedure known to all concerned and followed meticulously. In most hospitals after autopsy permission is obtained in writing from the legal nearest of kin, the chart and the permission are placed in the hands of the pathologist or physician performing the autopsy. It is his duty to ascertain any restrictions, partial permission as "abdomen only," and any other unusual features before proceeding with the autopsy.

Quite a few hospitals now have carbon copies made at the time of signing of the autopsy permit and have the original on the chart and the carbon for the pathologist's file.

How To Get C-3 Claim Number . . .

Bureau of Workmen's Compensation Cannot Supply It in Routine Cases; Reasons Are Enumerated Here; Alternative Plan Described; It Works

RECENT improvements in the administration of the Bureau of Workmen's Compensation have speeded up the processing of C-3 (medical-only) claims to the extent that James L. Young, BWC administrator feels that he cannot justify the additional expense required to furnish attending physicians with the claim numbers of all C-3's. This was requested by the Ohio State Medical Association, pursuant to a resolution adopted by the House of Delegates last year.

In explaining his decision, Young pointed out that up until November 1, 1957, the lag in notifying the employer of the number of C-3's was from 30 to 60 days. **Currently, the employer is notified of the number the next day after the claim is filed, so that any interested party should be able to get the number of the claim from the employer within a few days after it has been filed.**

No Delay on Most of Them

Young also explained that about 90 per cent of the C-3's are allowed promptly on filing. The other 10 per cent are either turned down or returned for the completion of information omitted from the blank. **When a C-3 is disallowed, the attending physician and the claimant, as well as the employer, are notified of that fact together with the number of the claim and the reason for disallowance.**

Young pointed out that under the new IBM system for the payment of fees in "medical-only" claims, physicians are now being paid within 30 days for services rendered in approved C-3 claims. The remittance form which accompanies the checks to physicians lists the name of the claimant and the number of each claim included in the monthly warrant.

Should Query Employer

If a physician does not find a particular claim on his remittance form, and he has not been notified that the claim has been disallowed, he should assume that something had gone wrong. He should then query the employer as to whether or not the claim had been forwarded to BWC, and if so, obtain the number of the claim in case he wanted to write BWC about it.

Since a comparatively small percentage of the "medical-only" claims would be in this category, it was Young's opinion that, in view of the recently-initiated improvements in administration at BWC, the expense of furnishing attending physicians with the numbers of all C-3's would not be justifiable.

Cost Cited

It would cost BWC approximately $15,000 a year to supply attending physicians with the numbers of all C-3's, according to Young. This is based on an estimate of 1,000 C-3's filed daily. Postage would run about $5,000 a year plus the salaries of three typists, in addition to the cost of desks and equipment. He stated that he had turned down a

ATTENTION EMPLOYER

PLEASE LEAVE THIS CARD ATTACHED TO FORM C-3 WHEN FORWARDING SAME TO THE BUREAU OF WORKMEN'S COMPENSATION

Claimant's Name

Employer's Name

Date of Injury

Attention Bureau of Workmen's Compensation PLEASE INSERT CLAIM NUMBER ALLOTTED AND RETURN	Claim Number Allotted →	

similar request from representatives of labor to furnish claimants with numbers of C-3's.

Another Solution Suggested

Some physicians who handle a considerable number of C-3 claims have found a solution to this problem. This procedure, which was explained in the February, 1953, issue of *The Ohio State Medical Journal,* is as follows, and is offered as a suggestion to other physicians:

When the physician sends the C-3 form to the employer, he staples to it, a self-addressed return postcard, carrying a two-cent stamp (usually a regular government two-cent card) with wording on the other side of the card **as shown in the accompanying sample on Page 520.**

To facilitate processing by the BWC, **the card should be stapled to the upper left-hand corner of the C-3, with the return address side down, and the side on which the claim number is to be stamped, in front.**

Black and Red Wording

Some of the cards are printed in black and red, the words "Attention Employer" and "Attention, Bureau of Workmen's Compensation," printed in red for emphasis.

The claimant's name, the employer's name and the date of the injury are typed on the card by the physician.

When the BWC receives a C-3 form to which one of these cards is attached, the clerk stamping claim numbers on the forms received that day, stamps the claim number on the postcard and at the end of the day, mails the cards.

Procedure Works Well

This procedure lets the physician know that the employer has filed the claim, when it was filed and the number given to the claim. He can then keep an up-to-date record in his own office and later, if he does not receive a check for services rendered within a reasonable time, he can contact the BWC and refer to the claim by number—an important point as it is difficult for the BWC to locate a claim and to answer correspondence about it unless the claim number is known.

Physicians who have adopted this plan say it works. Try it out. Those handling incoming claims at the BWC office will cooperate by stamping the number of each claim on each postcard attached and mailing such cards to the attending physicians. Don't overlook these important items: **The card must be self-addressed, must carry two-cents postage and must carry the name of the claimant.** The BWC cannot address the cards or affix postage.

Insurance Pays Record $2.5-Billion In Health Claims for Year

Benefit payments by insurance companies to Americans protected by health insurance policies amounted to a record $2.5-billion in 1957, the Health Insurance Institute reported. This figure represents a 16.1 per cent increase in benefit payments over the $2.1-billion paid in 1956.

Latest figures supplied by the U. S. Department of Labor in its 1957 Consumer Price Index showed 1957 medical care costs rose 4 per cent.

The Institute report is based upon a survey of the nation's insurance companies writing policies which help pay for doctor and hospital bills and for loss of income from accident or sickness.

The survey revealed that reimbursements through group insurance plans in force during the year totaled $1.8-billion, or 21.3 per cent over 1956, while payments through individual and family type policies amounted to $619-million, a rise of 3 per cent over the previous year.

Payments to policyholders covered under hospital expense insurance policies, the Institute further reported in listing the figures by type of service, amounted to over $1-billion, with $778-million paid under group policies and $224-million paid by insurance companies to individuals.

Reimbursements to defray the cost of surgeons' fees totaled $398-million, with $322-million received by holders of policies under group plans, and $76-million paid to persons covered by individual surgical expense insurance policies.

Persons covered for non-surgical medical care and treatment through regular medical expense insurance policies received a total of $71-million during the year. Group policyholders received $61-million while those covered by individual policies were paid $10-million.

Benefit payments to those protected against the cost of serious, or catastrophic illness or accident through major expense insurance policies, including supplemental and non-supplemental coverage to the basic health cost plans, amounted to $130-million. Group plan payments totaled $126-million, while individual contract benefits came to $4-million. Of particular note, added the Institute, is the fact that payments in 1957 through major medical policies, the fastest-growing form of health insurance, increased by 100 per cent over the year 1956.

In concluding its report of payments for health care by the insurance companies throughout the United States, the Institute stated that the increase in such payments reflects the continued efforts of the public to pay its doctor and hospital bills through the voluntary non-governmental mechanism.

Paryzek Memorial Planned . . .

Cleveland Colleagues of Former OSMA President Heading Up Committee That Will Receive Funds for Conference Room at St. Alexis Hospital

THE men who knew him best, his fellow staff members at St. Alexis Hospital in Cleveland, and his friends throughout Ohio, are planning a memorial to Dr. Harry V. Paryzek, who was President of the Ohio State Medical Association in 1941-42.

The memorial is to be a $125,000 penthouse conference room atop the five-story service wing which is to be built with the proceeds of the St. Alexis Hospital Million Dollar Building Improvement Fund Campaign.

Dr. Harold J. Barker is chairman of the Memorial Committee. Serving with him are Dr. William F. Boukalik, Dr. Chet Lulenski and Dr. Vitus Pekarek. Sub-committee members will be drafted from organizations to which Dr. Paryzek belonged.

Honorary members of the committee are Dr. Robert R. Bartunek, Dr. J. H. Budd, Dr. F. W. Dixon, Dr. E. F. Kieger, Dr. J. L. Reycraft, Dr. James N. Wychgel, all of Cleveland; Dr. G. W. Petznick, Lakewood; Dr. J. G. Kramer, Akron; Dr. E. J. McCormick, Toledo; Dr. H. M. Platter and Mr. Charles S. Nelson, Columbus; and Dr. E. O. Swartz and Dr. L. H. Schriver, Cincinnati.

Those who wish to share in the memorial to Dr. Paryzek may mail their contributions to "The Harry V. Paryzek Memorial Fund, c/o St. Alexis Hospital, 5163 Broadway, Cleveland 27, Ohio."

Names of those who contribute will be placed in a permanently bound book to remain in the conference room. A formal dedication of the new room will be held.

Dr. Paryzek's long medical career began in 1915, following his graduation from the Western Reserve University School of Medicine. He served in Europe during World War I with the famed Lakeside Unit, after which he returned to Cleveland and private practice.

After several years association with City Hospital in Cleveland, Dr. Paryzek became director of Medicine at St. Alexis Hospital in 1930, and Chief of Staff.

Prominently associated with both the local and state medical associations, Dr. Paryzek in 1933 was President of the Cleveland Academy of Medicine. His initial work on the state level was as Chairman and Secretary of the OSMA Section on Medicine. In 1932 he was elected a member of the Council of the State Association, representing the Fifth District.

After serving on a number of important committees, Dr. Paryzek was elected President-Elect of the Ohio State Medical Association in 1940, served as president during 1941-42. At the time of his death, Dr. Paryzek was chairman of the OSMA Committee on Chronic Illness.

Besides his active participation in medical associations, he was a member of the Cleveland Garden Club, Men's Garden Club, Holden Arboretum, Audubon Society and Phi Chi and Alpha Omega Alpha Fraternities.

Four 24-Hour Poison Control Centers Operate in Ohio

Four locally supported Poison Control Centers are now operating within Ohio, the Ohio Department of Health bulletin reported. Each gives 24-hour service with a physician on call who will give information on request regarding symptoms and the latest recommended treatment on poisonings to physicians and hospital personnel. Limited emergency care data are available to other persons, but the importance of getting a patient under medical care is stressed. They are:

Akron Poison Control Center, Children's Hospital, W. Bowery & W. Bechtel, Akron; Telephone: BL 3-5531 (Ext. 246).

Columbus Poison Control Center, Children's Hospital, 561 S. 17th Street, Columbus; Telephone: CL 8-9783.

Cincinnati Poison Control Center, Kettering Laboratory, University of Cincinnati, Eden Avenue, Cincinnati 19; Telephone: CA 1-1414.

Poison Information Center, Cleveland Academy of Medicine, 2121 Adelbert Road, Cleveland 6; Telephone: CE 1-4455.

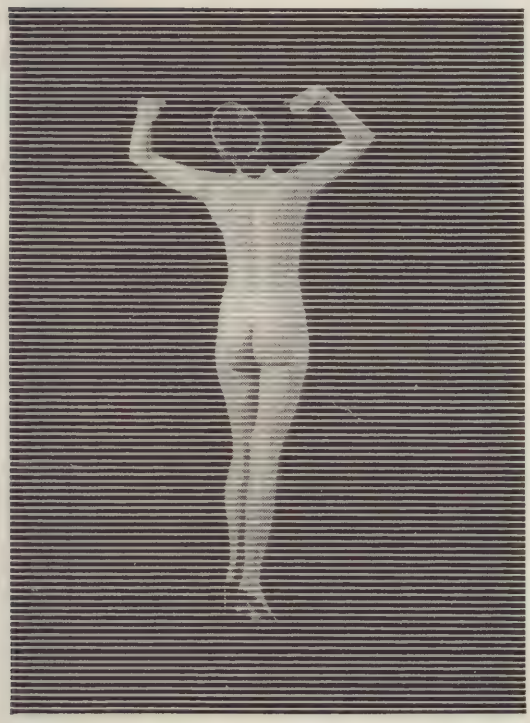
Psychiatric Clinic Directors To Hold Luncheon April 16

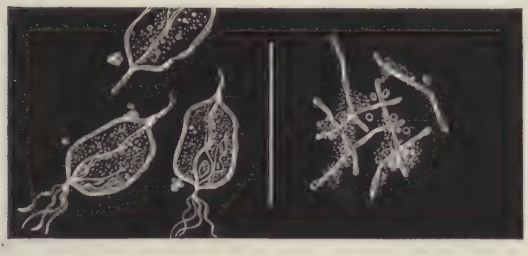
Ohio Association of Psychiatric Clinic Directors will hold a luncheon meeting at the Netherland Hilton Hotel on Wednesday, April 16, starting at 12:30 P. M. Place of the luncheon will appear on the hotel bulletin board. After the luncheon there will be informal discussion and a business session. Present officers of the organization are: Dr. Stuart Ducker, Dayton, president; Dr. Dorothy C. V. Heinz, Springfield, secretary-treasurer and president-elect.

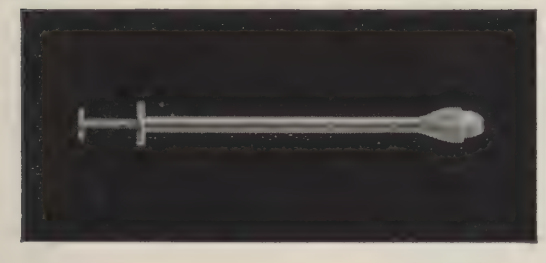
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SEARLE

In Memoriam . . .

Edwin W. Baker, M. D., Fremont; University of Buffalo School of Medicine, 1883; aged 98; died February 21; former member of the Ohio State Medical Association. Dr. Baker moved to Clyde from New York State 1887. He practiced there until 1929 when he moved to Fremont where he continued in practice until 1949, in which year he retired. He was a 32nd Degree Mason. Dr. E. A. Baker, of Clyde, is a nephew.

John Joseph Bowlen, M. D., Akron; University of Louisville School of Medicine, 1926; aged 56; died February 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Bowlen began practice in Akron in 1929. In 1942 he left for service in World War II and attained the rank of major, returning to Akron after two years in the Medical Corps. Survivors include his father, his widow, three daughters and two sisters.

Edward J. Braun, M. D., Cleveland; University of Pittsburgh School of Medicine, 1914; aged 67; died March 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Braun for 35 years was with the Cleveland Health Department. Before moving to Cleveland he practiced for short periods in Pittsburgh and Youngstown. He also was chief examiner for the local police department. A veteran of World War I, he was a member of the American Legion. Other affiliations included membership in the Cleveland Crime Commission, Phi Delta Epsilon and the Masonic Lodge. Surviving are his widow, a brother and a sister.

Clyde J. Cranston, M. D., Wakeman; Western Reserve University School of Medicine, 1924; aged 62; died February 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Cranston had been a practicing physician in Wakeman and vicinity since 1927. He previously practiced for a short time in Cleveland. A veteran of both World Wars, he was active in several veterans groups, including the American Legion, Veterans of Foreign Wars and the 37th Division AEF Association. His Army rank was that of lieutenant colonel. Other associations included memberships in the Association of Military Surgeons, the Masonic Lodge and the Congregational Church. Surviving are his widow, two sons, his mother and a sister.

Paul S. Craig, M. D., Washington C. H.; University of Cincinnati College of Medicine, 1928; aged 60; died February 21; member of the Ohio State Medical Association and the American Academy of General Practice. A native of Washington C. H., Dr. Craig practiced there from 1931 to the time of his death. One of his interests was Berea College, Berea, Ky., where he often went to conduct physical examinations as a member of the medical staff. Surviving are his widow and two brothers.

George E. Dash, M. D., Boothbay Harbor, Maine; Eclectic Medical College, Cincinnati, 1905; aged 75; died February 17; former member of the Ohio State Medical Association; member of the American Academy of Pediatrics. Dr. Dash practiced in Cincinnati until his retirement in 1947. for some 30 years he was head of the medical department at Children's Home, Cincinnati. Surviving are his widow, a son and a brother.

Joseph H. Dempsey, M. D., Cleveland; Western Reserve University School of Medicine, 1912; aged 72; died March 6; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Dempsey practiced there in the Euclid-Collingwood areas for about 46 years. He was a member of the Catholic Church. Surviving are his widow, three daughters and seven sons, one of whom is Dr. Joseph H. Dempsey, Jr., also of Cleveland.

Wilbur S. Ellis, M. D., Columbus; Miami Medical College, Cincinnati, 1896; aged 83; died February 17; member of the Ohio State Medical Association and the American Medical Association. A former practicing physician in Pomeroy for many years, Dr. Ellis was living in Columbus following his retirement. He also was Meigs County health commissioner for a number of years. Three daughters survive.

Beatrice Todd Hagen, M. D., Zanesville; University of Buffalo School of Medicine, 1900; aged 81; died February 13; former member of the Ohio State Medical Association; former secretary of the Muskingum County Medical Society. Dr. Hagen was honored by the Muskingum County Medical Society in 1950 for a half century of service in the medical profession. She moved to Zanesville in 1908 where she was a practicing physician and health commissioner. Her service as county health commissioner extended from 1928 to 1950 and as city health commissioner, from 1922 to 1926. Affiliations included memberships in the Episcopal Church and the Zanesville Business and

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1. Welch, H.; Wright, W. W.; and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 4:620, 1957.

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Also available: **PANALBA KM GRANULES** (Pediatric). When reconstituted, each 5 cc. teaspoonful contains Panmycin equivalent to tetracycline hydrochloride, 125 mg. and Albamycin (as novobiocin calcium) 62.5 mg., and potassium metaphosphate 100 mg.; in pleasantly flavored vehicle. Dosage is based upon amount of tetracycline—6 to 8 mg. per pound of body weight per day in 2 to 4 equally divided doses.

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USUAL DOSAGE: ADULTS: 1 or 2 capsules every 6 hours. CHILDREN: Proportionately less.

SUPPLIED: Each brown-and-pink capsule contains tetracycline phosphate complex, equivalent to 250 mg. tetracycline hydrochloride; nystatin 250,000 units. In bottles of 16 and 100.

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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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Professional Women's Club. Surviving are a son and a daughter.

Gerald Watson Hamilton, M. D., Akron; Rush Medical College, 1921; aged 60; died February 26 as the result of an accidental shooting; member of the Ohio State Medical Association. A native of Geneva, Pa., Dr. Hamilton had been a practicing physician in Akron for 32 years. During World War II he served with the Army Medical Corps in the grade of captain. Survivors include his widow, three sons, a daughter and his mother.

Roy O. Knapp, M. D., Akron; University of Michigan Homeopathic Medical School, 1910; aged 73; died February 27; former member of the Ohio State Medical Association and the American Medical Association. Dr. Knapp was a practicing physician for many years in Akron. Survivors include his widow, a daughter, two sons and a sister.

Philip R. Linsey, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1910; aged 71; died February 10; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Cleveland, Dr. Linsey was a practicing physician there for 48 years, and was one of the founders of the Polyclinic Hospital. A former athlete, he was active in such organizations as the YMCA. He also was a member of the Singers Club, the City Club. Surviving are his widow, two sons, one of whom is Dr. Eugene Linsey; also a sister.

Anthony J. Looze, M. D., Cleveland; St. Louis University School of Medicine, 1915; aged 66; died February 26; member of the American Psychiatric Association. Dr. Looze was on the staff of Cleveland State Hospital for about seven years. He previously practiced for a number of years in Youngstown. Survivors include his widow, two daughters, and a sister.

James E. Mullen, M. D., Perrysburg and Toledo; Stritch School of Medicine of Loyola University, 1935; aged 49; died February 9; member of the Ohio State Medical Association, the American Medical Association and the Industrial Medical Association; Fellow of the American College of Surgeons. Dr. Mullen was a lifelong resident of the Toledo area and a practicing physician there since completion of his training. He is survived by his widow, a son, two daughters and a brother.

Edwin J. Oster, M. D., Cleveland; Western Reserve University School of Medicine, 1920; aged 63; died February 23; former member of the Ohio State Medical Association. Dr. Oster had been a

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practicing physician in Cleveland since the early 1920's. He is survived by his widow and a sister.

George W. Shepard, M. D., Oakland, Calif.; Western Reserve University School of Medicine, 1903; aged 79; died February 3. A native Ohioan, Dr. Shepard practiced for a short time in Ravenna before he became a career U. S. Navy surgeon. He is survived by his widow and a son.

Clyde K. Startzman, M. D., Bellefontaine; Indiana University School of Medicine, 1915; aged 68; died March 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Startzman was a practicing physician in Bellefontaine from 1915 with the exception of the period of World War I, during which he served with the Army Medical Corps. He was active in numerous civic affairs of the community; was a member of the local board of education, the city and county health department and served on the Bellefontaine Charter Commission. Survivors include his widow, two daughters, two sons, a brother and two sisters.

Howard L. Stitt, M. D., Cincinnati; University of Cincinnati College of Medicine, 1910; aged 73; died February 15; member of the Ohio State Medical Association, the American Medical Association and diplomate of the American Board of Otolaryngology. Dr. Stitt practiced in Washington C. H. from 1911 to 1921, in which year he went abroad for graduate studies. He returned and opened a practice in Cincinnati which he maintained until his retirement in 1955. He was a member of Nu Sigma Nu and several specialty societies. Surviving are his widow, a daughter, a son and a sister.

Ralph B. Taylor, M. D., Columbus; Eclectic Medical College, Cincinnati, 1898; aged 84; died February 23; member of the Ohio State Medical Association and the American Medical Association. A recipient of the OSMA 50-Year Award, Dr. Taylor actually practiced over a period of nearly 60 years. From 1940 to 1954 he served on the State Medical Board. A 50-year Mason, he was affiliated with several Masonic bodies. Survivors include a son and a daughter.

Francis W. Thomas, M. D., Columbus; Ohio State University College of Medicine, 1912; aged 68; died February 18 while vacationing in Florida; former member of the Ohio State Medical Association; member of the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Otolaryngology. Dr. Thomas practiced medicine in Columbus for 30 years before he retired in 1948. He was a member of the Episcopal Church. Surviving are his widow, a son, two brothers and two sisters.

Frank W. Watson, M. D., Columbus; Ohio State University College of Medicine, 1919; aged 63; died March 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Watson was a practicing physician in Columbus for 39 years. For a number of years he was physician for the Columbus Jets, and formerly for the Redbirds baseball team. Affiliations included memberships in the Kiwanis Club, the Scioto Country Club, several Masonic bodies, Nu Sigma Nu and the Methodist Church. Surviving are his widow, a daughter and a son, Dr. John Watson; also a sister and a brother.

Rudolf Weiss, M. D., Cleveland; graduate of the Medical Faculty, University of Vienna, Austria, 1917; aged 66; died March 2; member of the Ohio State Medical Association and former member of the American Medical Association. Dr. Weiss moved to Cleveland in 1939 after previously practicing for 17 years in Austria. Surviving are his widow and two step-daughters.

Chest Physicians To Present Program In Cincinnati, April 16

The Ohio Chapter, American College of Chest Physicians, will present a program in Cincinnati at the time of the OSMA Annual Meeting. The chapter will meet in the Sheraton-Gibson Hotel on Wednesday, April 16, for a 12 o'clock luncheon to be followed by the program.

Reservations for the luncheon should be made by contacting Dr. F. G. Kravec, Secretary-Treasurer, 243 Lincoln Ave., Youngstown. Speakers and program have been announced as follows:

The Participants

Harvey Mendelsohn, M. D., Department of Thoracic Surgery, Western Reserve University.

Harold Humphrey, M. D., Medical Director of Benjamin Franklin Hospital, Columbus.

Elmer Maurer, M. D., Department of Thoracic Surgery, University of Cincinnati College of Medicine.

Herman Nimitz, M. D., medical director, Dunham Hospital, Cincinnati.

12:00 Noon—Luncheon

Experience in the Management of Spontaneous Pneumothorax—Dr. Mendelsohn.

The Tuberculous Patient Two Years after Discharge from the Hospital—Dr. Humphrey.

Surgical Treatment of Stenotic and Insufficient Lesions of the Aortic Valve—Dr. Maurer.

Trends in Tuberculosis as Demonstrated by Recent Hospital Admissions—Dr. Nimitz.

Activities of County Societies . . .

First District

(COUNCILOR: FRANK H. MAYFIELD, M. D., CINCINNATI)

CLERMONT

The March 19 meeting of the Clermont Medical Society was held at the Milcroft Inn with Dr. F. S. Skeen as host. Guest speaker was Dr. Charles Ball who discussed the "Status of Pension Plans for M. D.'s."

HAMILTON

The Roger Morris Lecture was given on March 4 by Dr. Irving M. London, professor of medicine, Albert Einstein College of Medicine, New York. His subject was "The Metabolism of Hemoglobin and of Erythrocytes."

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

At the February 17 meeting of the Clark County Medical Society, Dr. Rupert Turnbull was not able to be present as scheduled.

Substituting as speaker was Mr. Jack Wood, Springfield C. P. A., who discussed the Federal Income Tax and other tax matters.

The National Doctor's Day program was discussed and announcement was made of the dinner scheduled on March 12 by the Auxiliary.

The subject of whether or not Social Security should be extended to include doctors was discussed. Dr. Davidson was asked to give the pro side of the subject and Dr. Beam the con side.

Dr. Ash presented a report of the Public Relations Committee meeting with representatives of the Pharmaceutical Association.

Dr. Richard Topagna was voted in as a member of the Society.

MIAMI

"Pitfalls in Management of Refractory Heart Failure," was the subject of a film shown at the March 7 meeting of the Miami Medical Society. Also at the meeting the pros and cons on Society Security coverage for physicians were discussed.

Third District

(COUNCILOR: JAMES R. JARVIS, M. D., VAN WERT)

ALLEN

"Recent Pharmacological Advances in Narcotics" was the theme of a talk by Dr. Louis Levy, Department of Pharmacology, University of Cincinnati, before the Lima and Allen County Academy of Medicine. Some 78 members and guests were present at the February 10 dinner meeting at the Shawnee Country Club.

MARION

The Marion County Academy of Medicine unanimously endorsed the establishment of a Marion County Mental Health Clinic during its regular monthly meeting held February 4 in the Marion General Hospital auditorium.

The endorsement followed a talk by Dr. John Imbody, president of the Marion County Mental Health Association, on the clinic movement in Marion County.

Presiding for the business session was Dr. Daniel Murphy, head of the organization.

The program featured a debate on "Social Security for Physicians" with the pro arguments presented by Dr. Paul Schildt of Cleveland, and Dr. Charles Pavey of Columbus responding with the disadvantages.

Academy members joined in a question and answer period following the presentation of the guest speakers. Introducing Drs. Schildt and Pavey was Dr. Albert Mogg, program chairman.

A refreshment period closed the meeting. — *Marion Star.*

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The March program of the Academy of Medicine of Toledo and Lucas County contained the following features:

March 7—"The General Congressional Situation in 1958 as It Concerns the Medical Profession," Warren E. Whyte, executive secretary of the AMA Committee on Legislation.

March 14, Pathology Section—"High Speed Motion Picture Photography in the Diagnosis of Congenital Heart Defects," Dr. F. Mason Sones, Cleveland Clinic.

March 20, General Practice Section—Symposium

(Continued on Page 531)

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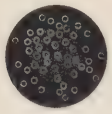
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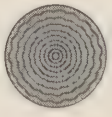
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PUTNAM

January meeting of Putnam Society was held at Hotel Dumont, Ottawa, January 7. Guest speaker was Dr. Forest C. Hunter, Lima dermatologist, who discussed "Common Diseases of the Skin."—H. N. Trumbull, M. D., Correspondent.

Members of the Society held their dinner meeting in the DuMont Hotel on February 3, at which time they endorsed the showing of the film, "Time and Two Women," sponsored by the American Cancer Society. Endorsement of the film for showing to local organizations, spearheaded a drive by the Putnam County Cancer Society to persuade women over 21 to have annual checkups.—*Ottawa Sentinal.*

SANDUSKY

The regular meeting of the Sandusky County Medical Society met at Serwin's Restaurant, February 19, 1958. Eighteen members were present. Dr. Swent presiding.

The minutes of the January, 1958, meeting were read and approved.

Dr. Swent announced the following:

1. That the Constitution and By-Laws had been read and approved by the Advisory Board consisting of Dr. Lee Moore, Dr. Richard Wilson, and Dr. E. E. Swint.

2. That a newly formed Medical Assistant's Society of Sandusky County had been organized, the purpose of this organization being to create a feeling of fellowship and cooperation among secretaries and assistants in office.

3. That Dr. Orr would attend the March Meeting and present 50 year certificates to Dr. Cooper of Bellevue, and Dr. E. H. Baker of Clyde.

4. That the state office had requested a poll to be taken on the question of social security. The program and its benefits were outlined in detail. A poll of the members present found 18 for, none against the medical profession to be included in the social security program.

Dr. Bates then discussed the April Meeting. He informed the members there would be three speakers, one on blood dyscrasias, one on fluid balance, and one on the roll of Psychology in Present Day Medicine. The meeting is to be held on April 23rd, at the Woman's Federation, Fremont. The cost will be $5.00 per person.

It was announced that Dr. Havener of O. S. U. would be the speaker at the March Meeting, his subject being diseases of the eyelids.

Dr. David Katchka from Toledo then spoke to



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the group on Local Anesthesia.—Paul E. Burson, M. D., Secretary.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

Guest speaker for the March 21 meeting of the Academy of Medicine of Cleveland was Dr. Ralph W. Gerard, professor of neurophysiology, Neuropsychiatric Institute, University of Michigan. Following a social period and dinner, Dr. Gerard spoke on the subject, "Schizophrenia and Psychopharmacology."

Among section meetings was that of the Experimental Medicine Section with the Cleveland Society for Experimental Biology and Medicine on March 24.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

About 40 members attended the dinner meeting of the Columbiana County Medical Society February 18 in the Wick Hotel in Lisbon.

The speaker was Dr. Charles L. Schmidt, associate professor of dermatology at the University of Pittsburgh and staff physician in Mercy Hospital, whose subject was "What's New in Office Dermatology." Dr. Roy C. Costello of East Liverpool, president, presided. Dr. J. W. Schoolnic and Dr. J. Fraser Jackson were co-chairmen.—*East Liverpool Review.*

MAHONING

Advances in the treatment of persons with heart conditions were detailed here before the Mahoning County Medical Society by Drs. F. Mason Sones and Donald Effler of the Cleveland Clinic.

Using slides and pictures, the physicians lectured before 200 members of the organization February 18 at the Elks Club in observance of "Heart Day," part of the month-long program of the Youngstown Area Heart Association. It will be climaxed next Sunday afternoon when 5,000 workers visit homes in a tri-county area asking for funds to continue the program of research, rehabilitation and education.

Dr. Andrew A. Detesco, president of the Mahoning County Medical Society, predicted such operations in Youngstown "in the foreseeable future."

Dr. Sones and Dr. Effler visited hospitals, met with interns and physicians, conducted clinical sessions and were the honor guests at a dinner meeting in the Youngstown Club.

The meeting was sponsored by the medical society, the Mahoning Academy of General Practice and the heart association.

In a short business meeting, the medical society members approved employment of a full-time executive secretary and authorized raising the dues to meet the additional expense.—Excerpts from *Youngstown Vindicator.*

STARK

Dr. Douglas Goldman, clinical director of Longview Hospital, Cincinnati, was guest speaker for the March 13 meeting of the Stark County Medical Society at the Belden Hotel in Canton. His subject was "Psychotherapeutic Drugs."

Distributed to members for proposed future action was a "Statement of Principles Governing Certain Relationships Between Doctors and Lawyers."

SUMMIT

For its March 4 program the Summit County Medical Society presented Dr. Paul A. Riemenschneider, professor of radiology, State University of New York, whose subject was "Radiation Hazard —Fact, Fable and Philosophy."

Dinner was served at the Akron City Club after which the program was held in the Akron General Hospital Auditorium.

TRUMBULL

Dr. Harry Shirkey, clinical professor of pediatrics at the University of Cincinnati, spoke before the February 20 meeting of the Trumbull County Medical Society. The combined meeting with the Auxiliary was held at the Trumbull Country Club.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

"Clinical Application of Isotopes," was the subject discussed at the March 10 meeting of the Scioto County Medical Society in Portsmouth. The speaker was Dr. Richard Goldsmith, associate professor of medicine, University of Cincinnati. The program was arranged by Dr. S. W. Miller.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

ROSS

Ross County Medical Society at a recent meeting passed a resolution urging City Council to reconsider as soon as possible its action in disapproving a second sanitarian for the City Health Department.

The resolution stated that the society recognizes the urgent need of a second sanitarian and emphasizes the fact that a city's budget curtailment should not commence with public health.

The sanitarian was excluded when the health de-

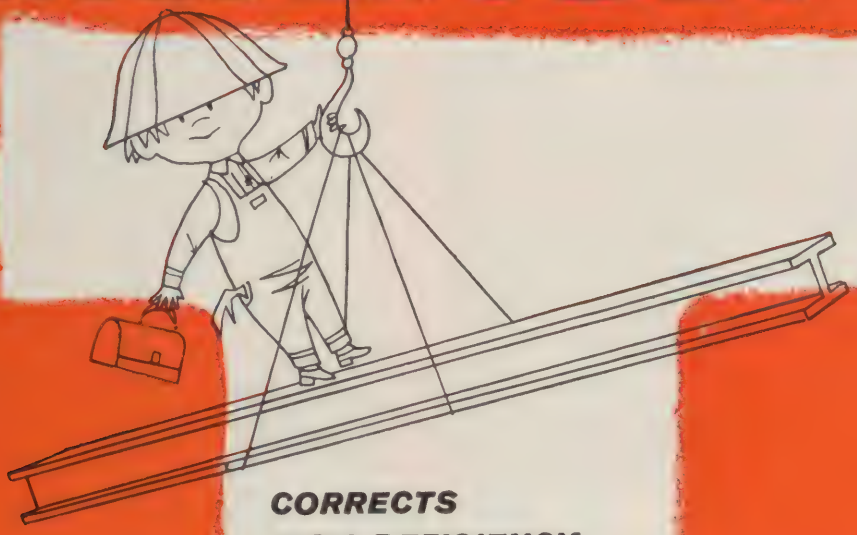
(Continued on Page 536)

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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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partment's budget was approved for 1958. It created a problem for the health department as the State Department has demanded an improvement in food service inspections in the city.

If the standards are not met, the state can step in and make the inspections, with a resultant loss of certain funds to the city.—*Chillicothe Gazette.*

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The February 11 meeting of the Lorain County Medical Society was held at the Oberlin Inn with 55 members in attendance.

Plans were laid for hiring an executive secretary for the Society.

A program was presented by Mr. Francis Calkins of Professional Management of Cleveland. The topic was "Doctors, Dollars and Taxes."—L. C. Meredith, M. D., Secretary-Treasurer.

RICHLAND

A meeting of the Richland County Medical Society was held at the Mansfield General Hospital, January 16.

Officers and delegates for 1958 are: President, Dr. C. F. Curtiss; vice-president, Dr. R. E. Frush; secretary-treasurer, Dr. J. J. Clark; delegates, Dr. P. O. Staker and Dr. Harry Wain; alternates, Dr. H. G. Knierim and Dr. R. H. Barnes.

Following dinner and a business meeting, Dr. Paul Fuzy, of Youngstown, gave an interesting talk on, "Complications in the Practice of Proctology"—John J. Clark, M. D., secretary.

Physical Medicine and Rehabilitation Program Scheduled April 16

The Central Section of the American Congress of Physical Medicine and Rehabilitation will meet for a program on Wednesday, April 16. The place is Parlors E and F, Netherland Hilton Hotel and the time 2:30 to 4:00 p. m.

Tentative program has been announced as follows:

Presiding: Dr. Keith Keeler, Akron.

"Research in Muscular Dystrophy," Dr. Paul Vignos, Cleveland.

"Aids in Diagnosis of Muscular Dystrophy," Dr. Rex McMorris, Louisville, Ky.

"Electromyographic Changes and Their Significance in Muscular Dystrophy," Dr. Edward H. Lambert, Mayo Clinic, Rochester, Minn.

"Treatment in Muscular Dystrophy," Dr. Kenneth Archibald, Cleveland.



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SURGERY—Surgical Technic, two weeks, May 12, June 16. Surgery of Colon and Rectum, one week, May 5, June 2. Basic Principles in General Surgery, two weeks, July 7. Gallbladder Surgery, three days, June 2. Surgery of Hernia, three days, June 5. General Surgery, two weeks, May 5; one week, May 12. Breast & Thyroid Surgery, one week, May 5. Fractures & Traumatic Surgery, one week, June 9. American Board Review Course, two weeks, Fall of 1958.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, June 2. Vaginal Approach to Pelvic Surgery, one week, July 14. General & Surgical Obstetrics, two weeks, June 16.

MEDICINE—General Review Course, two weeks, May 12. Electrocardiography, one week advanced course, June 16. Hematology, one week, June 2. American Board Review Course, one week, Sept. 29.

PEDIATRICS—Two-Week Intensive Course, Apr. 21. Neuromuscular Diseases; Cerebral Palsy, two weeks, July 7.

DERMATOLOGY—Clinical & Didactic Course, two weeks, May 5.

RADIOLOGY—Diagnostic X-Ray, two weeks, June 9. Clinical Uses of Radioisotopes, two weeks, May 5.

CYSTOSCOPY—Ten-Day Practical Course, by appointment.

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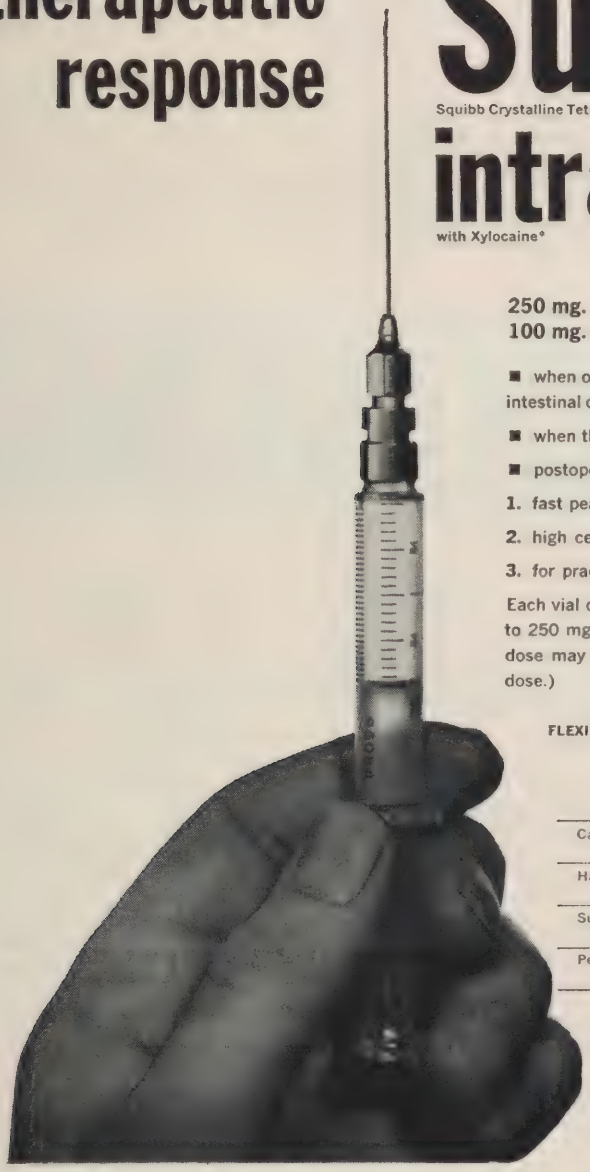
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(See Page 441 for roster of officers.)

BUTLER COUNTY

"Women's fashions, the rising birth rate and rock 'n' roll music were among the subjects covered by Tilman Ellison, Middletown director of law, in his humorous "Forecast for 1958" presented at a luncheon meeting of the Woman's Auxiliary to the Butler County Medical Society.

During the business session conducted by Mrs. Gilbert Wagoner, president, the appointment of Mrs. Donald Blizzard was approved by the members. Mrs. Marion Swisher, chairman of the American Medical Education Fund project, reported $240.97 had been collected in gifts and magazine subscriptions. The Hughes Hospital committee chairman, Mrs. J. A. Stewart of Hamilton reported $251.91 was spent on pajamas and personal items as Christmas gifts for the patients. This is an annual project.

Hostesses for the meeting, attended by 31 members, were Mrs. Jack Harris, chairman, Mrs. William Storer, Mrs. Louis Gaker, Mrs. James Sawyer and Mrs. John Bauer.

COLUMBIANA

The Woman's Auxiliary to the Columbiana County Medical Society met at the Masonic Temple for the regular monthly dinner meeting. Twenty members and one guest were present.

Mrs. Virgil Hart, president, presided at the business meeting. Mrs. William Horger announced that classes in Civil Defense are being held in East Liverpool. Mrs. Horger also participated on a radio forum on this subject. The project is sponsored by the local auxiliary. Mrs. Hart has been appointed to serve on the credentials committee at the State meeting in April.

Dr. Paul Beaver of Leetonia, was the guest speaker and he chose "Mental Health" as his topic. Dr. Beaver is a member of the Columbiana County Mental Health Association. He explained the work that the association is doing locally and asked for the cooperation of auxiliary members. A question and answer period followed the program.

Mrs. J. S. Jones was in charge of arrangements for the February meeting.

ERIE

Good fellowship keynoted the evening at the annual Doctor's Party given by the Medical Auxiliary for members of the Erie County Medical Society. A large group gathered at the Rieger Hotel dining room where dinner was served.

The speaker for the evening was George Boehm, publicity director of Musicarnival. He was introduced by Mrs. W. P. Skirball, auxiliary president. Mr. Boehm gave an interesting talk on a new concept in entertainment called "Theater in the Round."

Hostesses for the evening were Mrs. J. P. Ohlmacher, Mrs. W. R. Liebschner and Mrs. W. E. Birmingham.

FAIRFIELD

The Future Nurse Club of Lancaster High School held its February meeting in Lancaster-Fairfield Hospital. The girls met in the class room in the Nurses Home where Mrs. Robert Whetstone, medical social worker and wife of Dr. Robert Whetstone, Pleasantville, showed a film regarding her profession.

Following the film the girls were taken to the Nursing Arts Room. Here four freshman students from the School of Nursing, with the aid of an upper classman, enacted the do's and don'ts of bedside nursing. The skits were impressive and entertaining as well as informative.

The cooperation of Lancaster high school faculty and hospital personnel has enabled the sponsoring group of the Future Nurse Club to plan an outstanding program this year.

Two new projects, made possible through hospital participation are: an over night in the Nurses' Home for high school senior girls from the club and opportunity to do volunteer service in the hospital.

The sponsoring group for the Future Nurse Club is the Woman's Auxiliary to the Fairfield County Medical Society. Committee for the Auxiliary is composed of Mrs. Galon Rodabaugh, Mrs. William Jasper, and Mrs. Andrew Essman for the city and Mrs. F. A. Dowdy for the county.

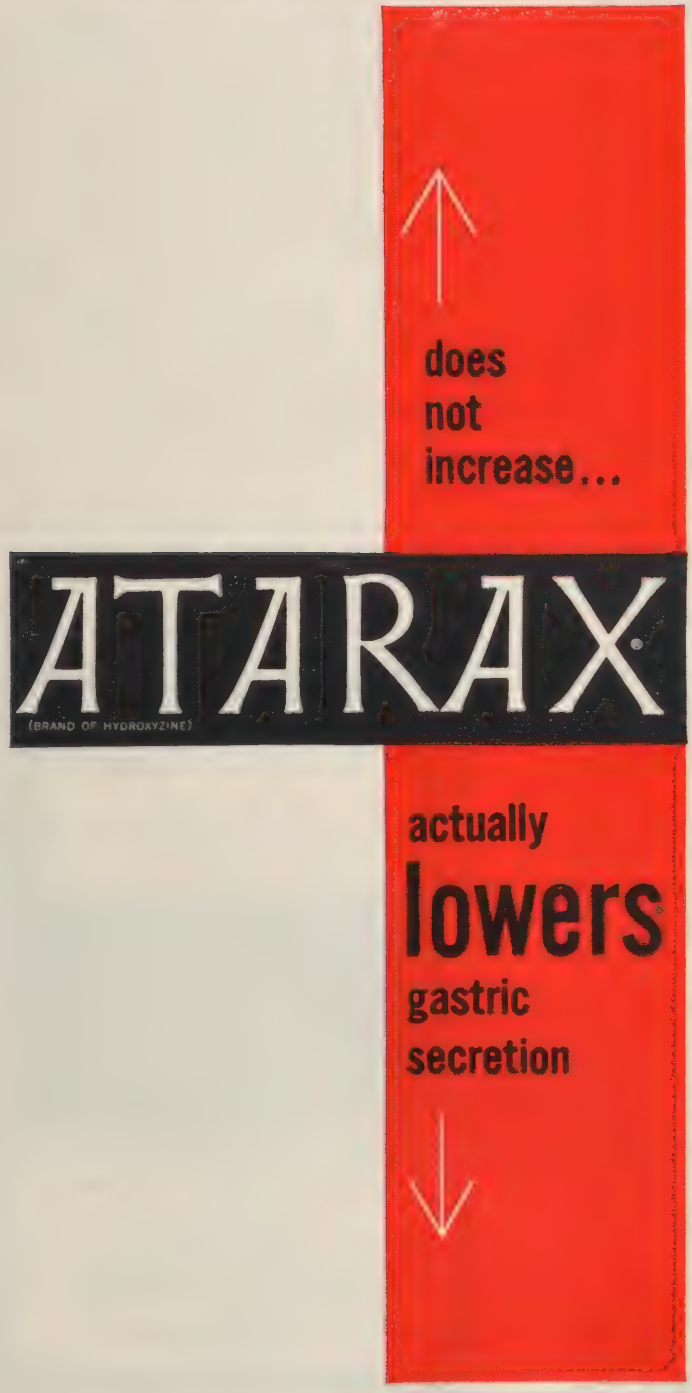
GREENE

Twenty-six prospective student nurses from Xenia and county high schools gathered in the assembly room of the Health Department at Greene Memorial Hospital as guests of the Auxiliary to the Greene County Medical Society.

Mrs. Hugh Schick, president, welcomed the girls. She introduced Miss Mildred Swanson, director of Nurses at Miami Valley Hospital, who spoke on "Careers in Nursing." Miss Swanson stressed particularly qualifications for entrance to schools of nursing and opportunities available to both graduate and practical nurses.

Dr. Gordon Savage explained the facilities of the Health Department. The guests were divided

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references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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into two groups and were conducted through the hospital.

Punch and cookies were served and each guest received a gift donated by a local pharmacy. Mrs. S. C. Ellis was in charge of the arrangements committee.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society heard the Reverend Lynn J. Radcliffe, pastor of the Hyde Park Community Methodist Church, speak on "Healing Ill Health from Within" on February 18. His talk followed a luncheon at the Cincinnati Club at which the president, Mrs. Gaston B. Hannah, accorded recognition to the group of physicians' wives who have organized and directed Future Nurse Clubs in 11 Greater Cincinnati high schools. Their efforts have been extended to include all related careers in health, and have stimulated the interest of more than 300 high school students this year.

The second in a series of orientation meetings for new members was held on January 29 at the home of Mrs. Roy L. Kile.

JEFFERSON

Mrs. D. R. Cahill entertained 21 members of the Woman's Auxiliary to the Jefferson County Medical Association at a luncheon on January 25.

A business session followed, with Mrs. W. B. Mikita presiding. Reports of the Future Nurse Clubs were given by Mrs. E. B. Weinman of the Steubenville High School Club and Mrs. Donald Myers and Mrs. Warren Snyder, Wintersville Memorial High School. Mrs. John Mantica announced that the pinning exercises of the Catholic Central High School Club will be held in the Holy Name Auditorium.

Mrs. Weinman reported that the current radio series, "Tea for Three," a program of questions and answers concerning health, is well received. "Tea for Three" may be heard over WSTV every Sunday afternoon at 1:15.

A review of the current medical legislation was given by Mrs. E. L. Perri. Mrs. Carl Goll, Seventh District Director, reported on the State Auxiliary legislation. Other committee reports were given by Mrs. Jonathan Yobbagy, Mrs. Walter Cunningham and Mrs. J. Ellison Gamble. Welcomed as as a new member was Mrs. E. D. Lee. Mrs. Cahill was assisted by Mrs. S. L. Burkhardt, Mrs. Yobbagy, Mrs. Earl Rosenblum and Mrs. L. J. Kerschgens.

LAWRENCE

The Auxiliary to the Lawrence County Medical Society met for the February meeting at the MacArthur Hotel for a luncheon. Mrs. Harry Nenni

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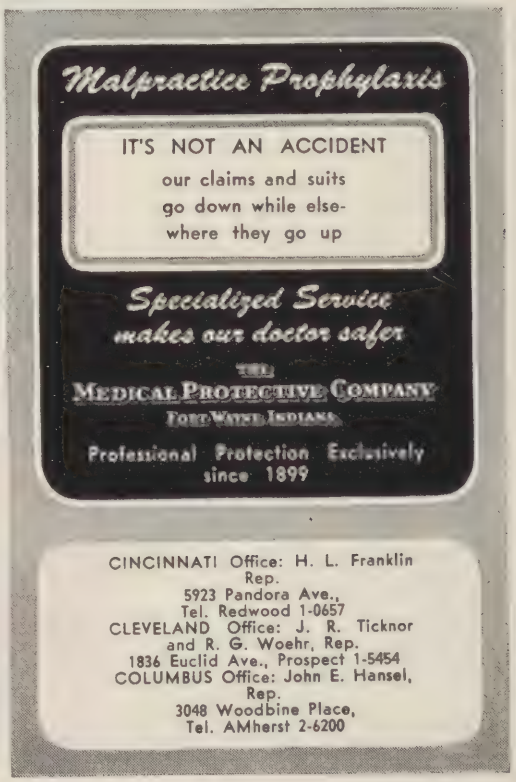
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and Mrs. G. K. Mahl, hostess, accented the luncheon with a valentine theme. Mrs. Charles Gallagher, president, conducted the business meeting.

The Auxiliary plans open house at the residence of Dr. and Mrs. Ralph Massie to honor the doctors of Lawrence County on National Doctors Day. Each doctor also will receive a boutonniere from the auxiliary.

Mrs. Leo Konieczny, chairman of *Today's Health,* reported 15 subscriptions had been mailed for local beauty salons. Nurse Recruitment is well underway. The local newspaper is carrying an announcement for girls who are interested in the Gift Certificate and Loan Program. It appears in the form of a 6x3 clipping, with the picture of a nurse, a place for them to fill out and return by mail to the chairman, Mrs. George Spears. A private jewelry sale is being planned and the proceeds will go into the General Fund.

Speakers for the afternoon were Mrs. George Cooper, 9th District Director from Waverly and Mrs. S. L. Meltzer, First Vice-President of the State Auxiliary from Portsmouth.

LOGAN

The Woman's Auxiliary to the Logan County Medical Society met in the home of Mrs. F. W. Kaylor for dessert, with a good attendance. Mrs. George Freetage, president, presided and conducted the business session. A nurse recruitment tea was planned. Committee reports were given and the following were elected to office: Mrs. Joseph Springer, president; Mrs. George Freetage, vice-president; Mrs. John Wolfe, president-elect; Mrs. George Gensmere, secretary; Mrs. C. K. Startzman, corresponding secretary; Mrs. John Traul, treasurer.

A safety program consisted of modeling hats decorated with items dangerous to children.

LUCAS

The seventh annual Mothers March on Polio was held on January 30. This project is organized and directed wholly by the Lucas County Auxiliary. Over 6,000 mothers collected at every home in Lucas County for funds for the local and national chapter of the Foundation for Infantile Paralysis.

Prior to the drive, the Auxiliary entertained all the workers at a tea at the Academy Building. There were over 300 present. Guest speaker was Mr. George N. Barrie, regional director for the National Foundation, whose theme for this year's drive was, "Survival is not enough." Miss Patty Hicks of Minneapolis, National Chairman of the very active and interested young group "Teens Against Polio," was a guest. Total collection for the hour's march was $56,653.38.

Mrs. J. W. Millis was chairman for the Mothers March with Mrs. Albert Bershon, Mrs. A. J. Blanchard and Mrs. Thomas Bowlus as co-chairman. The committee packaged over 6000 Mothers Kits needed for the workers. There was excellent press coverage. The radio station gave time for broadcasts before and during the March and the local television station gave time for three appearances to explain the necessity of continuing this project.

MAHONING

Members of the Woman's Auxiliary to the Mahoning County Medical Society invited guests for luncheon and style show on February 11 at Tippecanoe Country Club. Over 250 women were present. Sherry's Inc., showed an array of the newest in advance fashions for spring and summer and were modeled by members of the Auxiliary. Mrs. Marcus Kilch was the commentator.

Luncheon decorations were keyed to the valentine theme. Arrangements of flowers were distributed as prizes, the winners being Mrs. C. E. Pichette, Mrs. Victor Junius and Mrs. Leo Henry.

In charge of the event were Mrs. R. M. Foster and Mrs. James L. Calvin, chairman and co-

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chairman of the program committee. Mrs. F. A. Friedrich and Mrs. Frank Gellman headed the social committee.

RICHLAND

Thirty-seven members were present when the Woman's Auxiliary to the Richland County Medical Society met for luncheon at the Women's Club.

Guest speaker was Judge Herbert Schottler. His topic concerned "Estate Planning." Mrs. Paul Lee opened the business meeting; various committee reports were given; Mrs. Robert Tawse reported on Nurse Recruitment and informed the members that Mrs. Robert Crawford would be in charge of the Post-Graduate Scholarship Fund.

Each week members do volunteer work on the Bookmobile at Mansfield General Hospital. Mrs. Russell Barnes distributed literature concerning Civil Defense. Delegates were appointed to the State convention to be held in Cincinnati. Mrs. Harry Wain is the presidential delegate with Mrs. Milton Oakes and Mrs. C. F. Curtis as regular delegates. Mrs. R. E. Frush is alternate.

Hostesses for the day were Mrs. Karl Langacher, Mrs. John Hattery and Mrs. C. H. Bell.

SCIOTO

Approximately 450 freshman and sophomore girls from city and county high schools attended a tea and tour of Mercy Hospital and its school of nursing. The event was planned and sponsored by the Woman's Auxiliary to Scioto County Medical Society in the interest of nurse recruitment—a project of the auxiliary.

Highlighting a business meeting of the auxiliary following the tea and tour was an announcement by Mrs. George W. Martin, chairman of the nominating committee.

The 1958-59 officers will be Mrs. Armin A. Melior, president; Mrs. William Singleton, vice-president; Mrs. A. Louis Berndt, president-elect; Mrs. L. B. Hatch, secretary; Mrs. G. E. Neff, treasurer; Mrs. Milton Levine, historian, and Mrs. B. U. Howland and Mrs. Martin, advisory board.

Mrs. J. T. Gohmann and Mrs. Hatch were co-chairmen of the tea and tour for the high school students.

Tours were conducted in small groups by student nurses after the young visitors were shown a film on a nursing career from the University of Pennsylvania.

The tea was held in the recreation room of Madonna Hall. Mrs. William C. Hugenberg and Mrs. Martin poured.

Mrs. Hugenberg, president, conducted the business meeting in the library of Madonna Hall after the dismissal of the student guests.

STARK

George Washington's birthday provided the decorating theme for the tea table at the meeting of the Woman's Auxiliary to the Stark County Medical Society on February 18 at the Canton Garden Center.

Mrs. Richard Spitzer presided. Delegates were elected for the annual meeting of the State organization. They are Mrs. Mark Herbst, Mrs. John Seesholtz and Mrs. Roy Clunk. Alternates are Mrs. William White, Mrs. Delmar Gard and Mrs. John Thompson.

Contributions were made to the American Medical Education Fund for which Mrs. Herbst is chairman.

Wallet health cards were distributed by Mrs. Harold Bowman, chairman. A report was given by Mrs. Howard Ickes on the participation of Stark County Schools in the A. A. P. S. essay contest.

Miss Carol Pederson, president of the McKinley Future Nurses Club, presented a brief talk on the activities and opportunities of her club.

Following the business meeting pictures of the Holy Land were shown and narrated by Mrs. L. E. Leavenworth.

Mrs. Sam Maxwell, chairman, was assisted by Mrs. W. A. Lieser as co-chairman.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for a luncheon on February 4 at the Sheraton-Mayflower Hotel.

The meeting was planned around Health in cooperation with the coming 11th Annual Health Days to be held at O'Neil's Auditorium in Akron. Mrs. J. W. Parks is chairman and Mrs. E. L. Mollin is co-chairman. The auxiliary invited as their guests the Dental Auxiliary and members of interested health and welfare agencies.

Mrs. R. R. Pliskin introduced the speaker W. W. Bauer, M. D., who is Director of the Bureau of Health Education of the American Medical Association. The title for his talk was "The Nation's Health is Good."

Chances were sold on the floral table decoration and the proceeds went for A. M. E. F. fund.

TRUMBULL

The Trumbull County Medical Auxiliary held its monthly meeting on February 20 in the Trumbull Memorial Nurses Lounge. Special guests for the day were honorary members and past presidents. Following a short business meeting conducted by the president, Mrs. Clyde Muter, the

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...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

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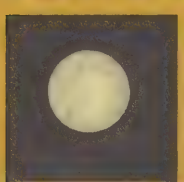
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Phenobarbital . . . . . gr. ¼
Acetophenetidin . . . . . gr. 2½
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Everything you need for taking an accurate, permanent, directly-recorded electrocardiogram is now available in a "package" the size of a portable typewriter, and that weighs only 18 pounds! *This* is the new Model 300 VISETTE — a completely modern, transistorized ECG recently introduced by Sanborn Company. The unique design has made possible for the first time a clinically *accurate* instrument that is *truly* compact and fully portable.

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A comprehensive folder describing the Model 300 VISETTE electrocardiograph is available on request. Or call the Sanborn Company Branch Office or Service Agency in your locality for a demonstration in your office — to see for yourself the advantages of owning the ECG that "brings 'cardiography to your patient."

The established Sanborn Model 51 Viso-Cardiette is also available for those who prefer a larger, heavier (34 lbs.) instrument — $785.00, delivered. Many doctors use their "51 Viso" in the office and the Visette on "cardiograph calls."



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members and guests were treated to a delightful showing of new spring hats. Mrs. Paul Russell, of Strouss-Hirshbergs, conducted the show and Mrs. Fannie Bauman and Mrs. Evelyn Thayer were the models. Student nurses from the senior class assisted the co-hostesses, Mrs. Morton Crow and Mrs. Thomas Wilson, in serving tea after the meeting.

TUSCARAWAS

Dr. and Mrs. Paul Ebert's home in Dover was set up as a "disaster station" when the Woman's Auxiliary to the Tuscarawas County Medical Society held a civil defense program.

Sixteen members and two guests, Mrs. J. S. Bates of Dover and Mrs. James F. Zeller, attended. Special guests were several nurses from Union Hospital.

O. C. Wallace, Tuscarawas county civil defense director, was guest speaker and discussed the national, state and local levels and preparation for civil defense. After his informative talk, a film entitled "Communications during a Disaster" was shown by Sergeant Kincaid of the Canton Filter Center. The program was in charge of Mrs. J. W. Hamilton of Dover and she presented an appropriate skit.

Table decorations were in keeping with a civil defense theme. Mrs. George Woodward of Dover was hostess chairman and assisting her were Mrs. Paul Hisrich, Mrs. Bates, Mrs. Frank Yeager and Mrs. Jurgis Balciunas.

During the business meeting, it was announced that the Auxiliary's Yuletide Tour had netted $918 and that sum will be applied to the nurses' loan fund. It also was announced that the physicians in Tuscarawas County donated $725 to the American Medical Education Foundation.

The Auxiliary currently is sponsoring an essay contest in cooperation with the Association of American Physicians and Surgeons. Officials of seventeen high schools, public and parochial, in the county have been contacted and have expressed their desire for student participation. The local Medical Society is offering a $50 savings bond for best essay entered. Second prize will be a $25 bond and third prize $10 in cash. The three winning essays will be placed in the state competitions. All materials for the contest have been distributed to the schools and are available to the pupils.

An official communication from the Armed Forces reported that Captain Harold G. Kelso, Jr., recently participated in the 7th US Army maneuver, Operation Sabre Hawk, which involved more than 100,000 men in Germany. He is scheduled to return to practice in Dayton about January, 1959.

Procedure To Be Taken in Emergency When Medicare Identification Card Is Not Available

What procedure may the doctor follow under emergency conditions when the patient claims to be eligible under the Medicare program but does not have the required identification card?

These circumstances have arisen frequently and for that reason the Office for Dependents' Medical Care has set up a procedure to be followed by physicians and hospitals. The procedure as stated in ODMC Letter No. 10-58 is as follows:

The primary means of identification continues to be the DD Form 1173. When this identification card is not available and treatment is required under emergency conditions and similar circumstances (to mean those instances in which treatment is necessary for the preservation of life, health, or well-being of the patient, including in general, bodily injuries, medical or surgical conditions, and obstetrical and maternity care) one of the following forms of identification will be acceptable:

a. Statement of a local commander having knowledge of the sponsor's status that the patient is a bona fide dependent.

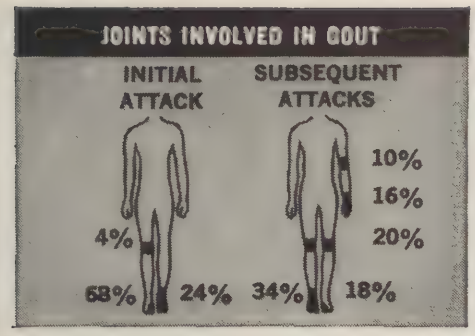
b. Other official uniformed services documents and/or identification cards signed by an official, reflecting the patient as being a dependent eligible for civilian care under Medicare.

c. Statement of the physician or hospital authority that he has personal knowledge of the identification of the patient, of her dependency status, and eligibility for civilian care under Medicare.

d. Civilian type identification such as Social Security card, driver's license, etc., identifying the party certifying to eligibility in Section III of the claim form as being the individual so stated. When this type of identification is used, care should be exercised in assuring that the name on the identification document used is the same as the name signed in Section III.

The statement as to the reason why the DD Form 1173 was not available should be obtained by the administrative agency. However, in those instances where obtaining such statement is not practicable and the above identifying documentation is available, the agency may waive this latter requirement and the claim form annotated accordingly.

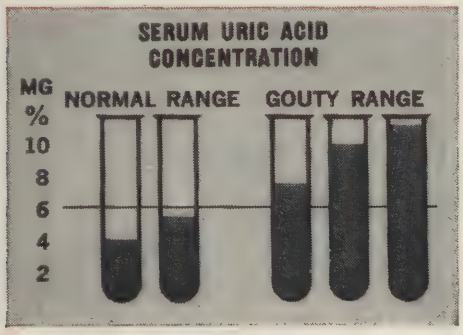
Undated or expired cards are not considered acceptable and, in those instances where expired cards are presented, the same provisions apply as if no card were presented. Identification cards containing the word "Indefinite," or abbreviation



1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

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thereof in lieu of a specific date, are considered acceptable.

The above requirements are applicable for all claims reflecting a beginning date subsequent to 31 December 1957.

* * *

Medicare Authorizes the Billing of Drugs for Maternity Patients

The following communication in regard to furnishing of drugs to maternity patients under the medicare program is from Maj. Gen. Paul I. Robinson, executive director, Office for Dependents' Medical Care:

1. Nothwithstanding paragraph 6 of ODMC Letter No. 4-58 or the absence of specific reference in the "Medicare Manual and Schedule of Allowances," as included in contract restatements and extensions, the provisions of paragraph 4j, ODMC Letter No. 4-58 relating to the furnishing of drugs to maternity patients will continue in effect until further notice.

2. In other words, the policy of permitting physicians to add to their statements (DA Form 1863) their cost of those drug items which have been directly or indirectly furnished to a maternity patient is continued in effect. (Direct furnishing of drugs is: supplying drugs by the physician's office to the patient; indirect furnishing is: the physician writes a prescription to the patient but has the pharmacy bill him, the physician, for the drugs dispensed.)

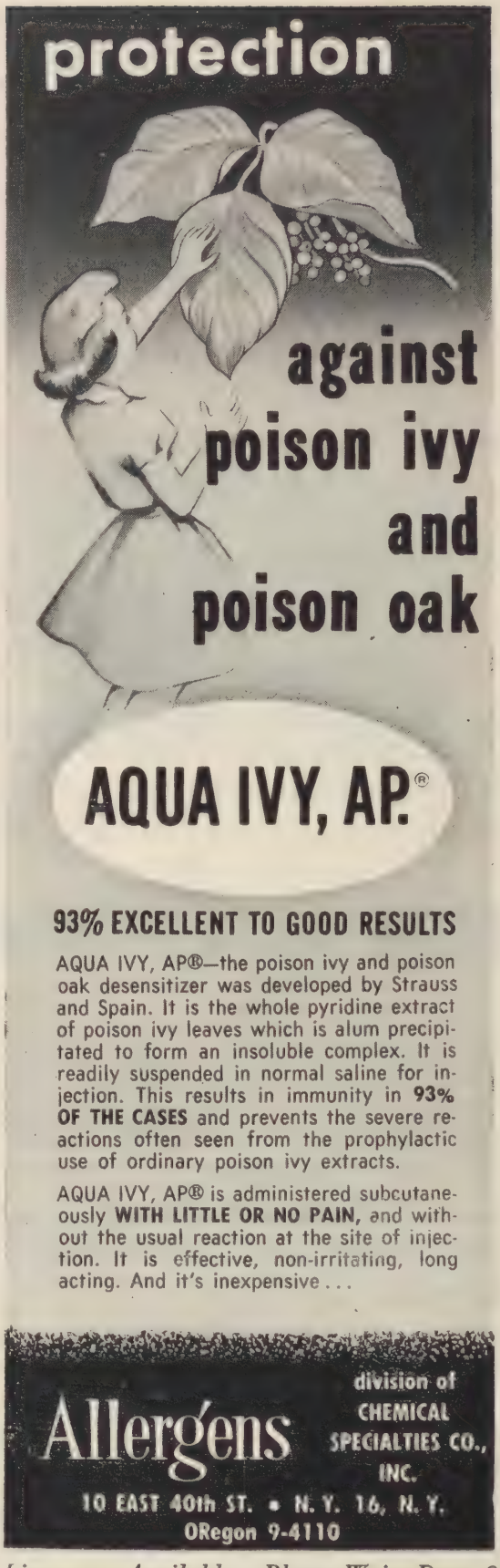
3. In order to be considered payable as a "complete" claim, the itemized cost of drugs furnished to maternity patients must be entered on the Claim Form (DA Form 1863) or attached thereto. Minimum itemization must include: the quantity, the nomenclature, and the cost of the drugs.

Influenza Blamed for Slight Decrease In Life Expectancy Last Year

After rising without interruption for 13 successive years, the average length of life of American wage earners and their families decreased slightly in 1957 from the all-time high of 70.2 years established the year before, it is reported by statisticians of the Metropolitan Life Insurance Company. The setback is attributed largely to the effect of the Asian influenza outbreak in the last months of 1957.

According to provisional mortality figures for 1957, the average length of life (expectation of life at birth) was 69.9 years, or 0.3 years below that for 1956.

In spite of the decrease the figure for 1957 exceeded by 3½ years that of a decade ago and by 23½ years the figure for 1909.



Literature Available - Please Write Dept. O

Buckeye News Notes

Portsmouth—"Cancer and Detection of Cancer" was the topic used by Dr. Robert N. Counts in addressing the Business and Professional Women's Club.

Painesville—Dr. J. G. McClellan spoke on prescribed methods for losing weight, before a meeting of the Home Demonstration Weight Watchers.

Euclid—The lecture hall in the new diagnostic wing of the Euclid Clinic Foundation has been named the "Hudson DeMott Fowler, Sr., M. D., Lecture Hall" in honor of Dr. Fowler.

Massillon—The Massillon Woman's Club heard Dr. Donald Pocock speak on heart disease.

Marion—The value of youth work and the need for youth leadership was the topic taken by Dr. Robert T. Gray in addressing the Kiwanis Club.

Ravenna—Dr. Robert Roy spoke on cause and effects of rheumatic heart disease before the Immaculate Conception Church Parents Club.

Findlay—The Kiwanis Club heard an address on "Medical Aspects of Civil Defense" by Dr. C. H. Evans.

Cleveland—A newly-elected member of the John Carroll University advisory board of lay trustees is Dr. A. Carlton Ernstene.

Youngstown—Food allergies was the field discussed by Dr. Clyde Walter in a talk before the Mahoning Valley Dietetic Association.

Bucyrus—The W. G. Carlisle Elementary School has been so named in honor of Dr. W. G. Carlisle for his outstanding medical, community and school services.

Piqua—The Central Ohio Heart Association has honored Dr. John T. Quirk for his 10 years of activities in and for that organization.

Madison—Dr. and Mrs. Julian V. Winans recently observed their 70th wedding anniversary.

Gallipolis—Sixth grade youngsters were helped in their study of the heart by Dr. Joseph P. Brady, who used slides and a heart model in speaking to the class.

Washington Court House—In memory of the late Dr. N. M. Reiff, a heart "pacemaker" and defibrillator have been presented to Fayette County Memorial Hospital.

Ashtabula—Junior Mothers of the Child Conservation League heard Dr. James Atkinson speak on child development.

Lima—"Sex Education" was the subject taken by Dr. Nathan Kalb in an address before the Child Study Group, Lima Branch, American Association of University Women.

Dr. Iler Named as a Member of The State Medical Board

Governor C. William O'Neill has named to the State Medical Board Dr. Harris D. Iler, of Cleveland and Lakewood, for a seven-year term. He succeeds Dr. H. Karl Dimlich, who died last September.

Dr. Iler is a native of Osceola, Michigan, and a graduate of Western Reserve University School of Medicine, class of 1927. He was licensed to practice in Ohio that same year. His training continued in Cleveland where he interned at Lakeside Hospital and Blodgett Memorial Hospital and later as a resident also at Lakeside. He took special training in surgery at Lakeside and the Cleveland Clinic and entered general practice in 1930.

Appointments include those on the staffs of Lakewood, Fairview Park, Berea and Lutheran Hospitals. Dr. Iler is on the Board of Directors of the Academy of Medicine of Cleveland and has served on the Academy's Committee on Ethics, both as a member and as chairman; also on the Legislative and Military Advisory Committees. He is a member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. His military record includes service in the Army Medical Corps from 1942 to 1945 where he attained the rank of lieutenant colonel. Dr. Iler is married and the father of three children.

Other members of the State Medical Board are: Dr. J. N. McCann, Youngstown; Dr. J. O. Watson (osteopath), Columbus; Dr. W. M. Hoyt, Hillsboro; Dr. Donald F. Bowers, Columbus; Dr. Horace B. Davidson, Columbus; Dr. John D. Brumbaugh, Akron, and Dr. Frederick T. Merchant, Marion. Dr. H. M. Platter is secretary to the Board.

Mount Gilead—Dr. David J. Hickson has been elected president of the Central Ohio Mental Health and Guidance Center board of directors.

Cleveland—The Cory Methodist Church has honored Dr. I. B. Scott for his 30 years of service as general superintendent of the church school.

Cincinnati—Dr. John F. Mueller, assistant professor in the Department of Internal Medicine, University of Cincinnati, took part in the first Oklahoma colloquy on advancements in medicine. He gave two talks, one on "Clinical Studies in Patients Receiving Long-Term Infusion of Fat Emulsions," and the other, "Physiologic Observations on Fat Transport—Utilization of Intravenous Emulsions."

Cleveland—Dr. Frederick C. Robbins is scheduled to appear on the program of the Hawaii Summer Medical Conference in Honolulu, July 1 - 3.

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Health Costs of the Aged. Collection of data pertinent to problems of providing older people with adequate medical care. Statistical information includes use of physicians' services and medical costs. (65 cents) Write U. S. Government Printing Office, Division of Public Documents, Washington 25, D. C.

* * *

Helping Children in Trouble. Stresses importance of reaching children with behavior problems before their problems become acute. Suggests how community can help. (15 cents) Write Government Printing Office, Division of Public Documents, Washington 25, D. C.

* * *

To the People We Serve. Explains county medical society programs and committees, budget plan, emergency procedure; for patients, lay readers. Write Lycoming County Medical Society, Williamsport, Pa.

* * *

The Effects of Nuclear Weapons. Comprehensive summary of latest knowledge of effects of nuclear weapons, including nuclear, residual nuclear and long-term radiation. ($2) Write Superintendent of Documents, Washington 25, D. C.

* * *

How to Use Local Television and Radio in the Health Field. Down-to-earth material resulting from the joint conference of the American Medical Association and the National Association of Radio and Television Broadcasters. Write AMA, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

What Is an Ophthalmologist? Folder gives definitions designed to give lay people better understanding of eye care. Write National Medical Foundation for Eye Care, New York City, New York.

* * *

Self-Evaluation Schedule for Medical Assistance Programs. This 35-page booklet gives the blueprint for analysis of programs. ($1) Write American Public Welfare Association, 1313 East 60th Street, Chicago 37.

Ohioans Take Part In AMA Rural Health Session

Ohioans took prominent part in the AMA's 13th National Conference on Rural Health, held at Jackson, Miss., March 6-8, in which Dr. Carll S. Mundy, Toledo, presided over the opening session. He is vice chairman of the AMA Council on Rural Health.

Dr. Robert E. Reiheld, Orrville, a member of the OSMA Committee on Rural Health, was one of the speakers at the meeting, his topic being the OSMA preceptorship program at the University of Cincinnati College of Medicine.

Dr. E. K. Yantes, Wilmington, chairman of the Rural Health Committee, and Robert E. Rakel, Cincinnati medical senior and national president of the Student AMA, participated in a roundtable discussion of medical education which is to be published in *The New Physician.*

Discussion leader for the entire conference was Jacob P. Schmidt, Ph. D., extension professor, Agricultural Extension Service, Ohio State University, assisted by Mrs. Schmidt. Also attending was Charles W. Edgar, OSMA headquarters staff, secretary of the Rural Health Committee.

Cleveland Anesthesiologist To Have Dr. Lull As Guest Speaker

Dr. George F. Lull, Assistant to the President of the American Medical Association, will be guest speaker for the Whitacre Memorial Address, sponsored by the Cleveland Society of Anesthesiologists. His talk entitled "The Regulated Practice of Medicine," will be given at a dinner meeting at the Wade Park Manor in Cleveland, on Wednesday evening, April 23. Interested persons should contact Sidney W. Helperin, M. D., 20665 Century Way, Maple Heights, Ohio.

Clinical Electrocardiography Course at Huron Road

The Medical Staff of Huron Road Hospital, Cleveland, will present a two and a half day postgraduate course in Clinical Electrocardiography on May 2, 3 and 4. The emphasis will be placed on the clinical aspects of electrocardiography as used in clinical practice.

Basic concepts of electrocardiography will be reviewed but the discussions will center around the interpretation of multiple precordial and unipolar and bipolar extremity leads.

The American Academy of General Practice will allow credit of 15¼ hours for this course.

Details may be obtained from the Huron Road Hospital, 13951 Terrace Road, Cleveland 12, Ohio.



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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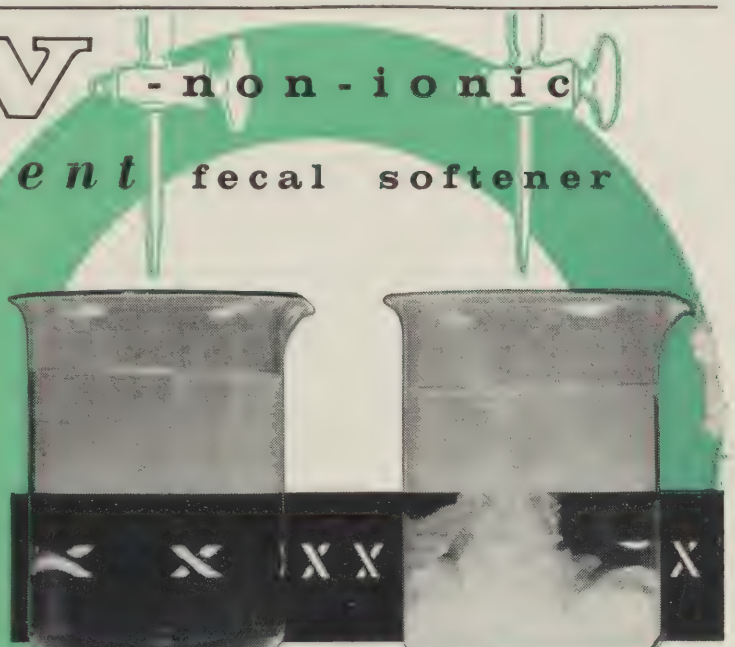
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* J.A.M.A. *166*:158,1958; Welsh, A.L. and Ede, M. "...*prompt remissions of ... acute phases.*" with TARCORTIN

1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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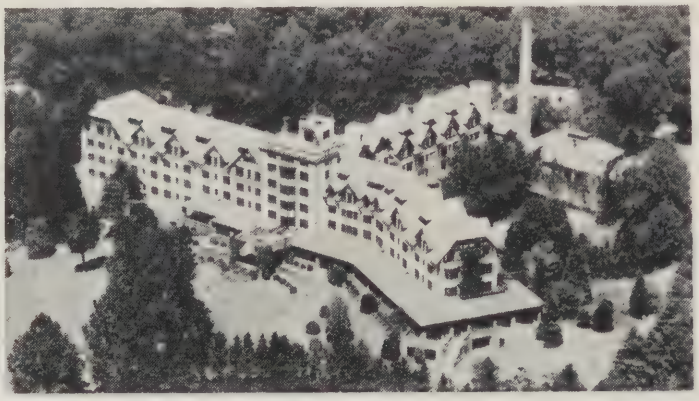
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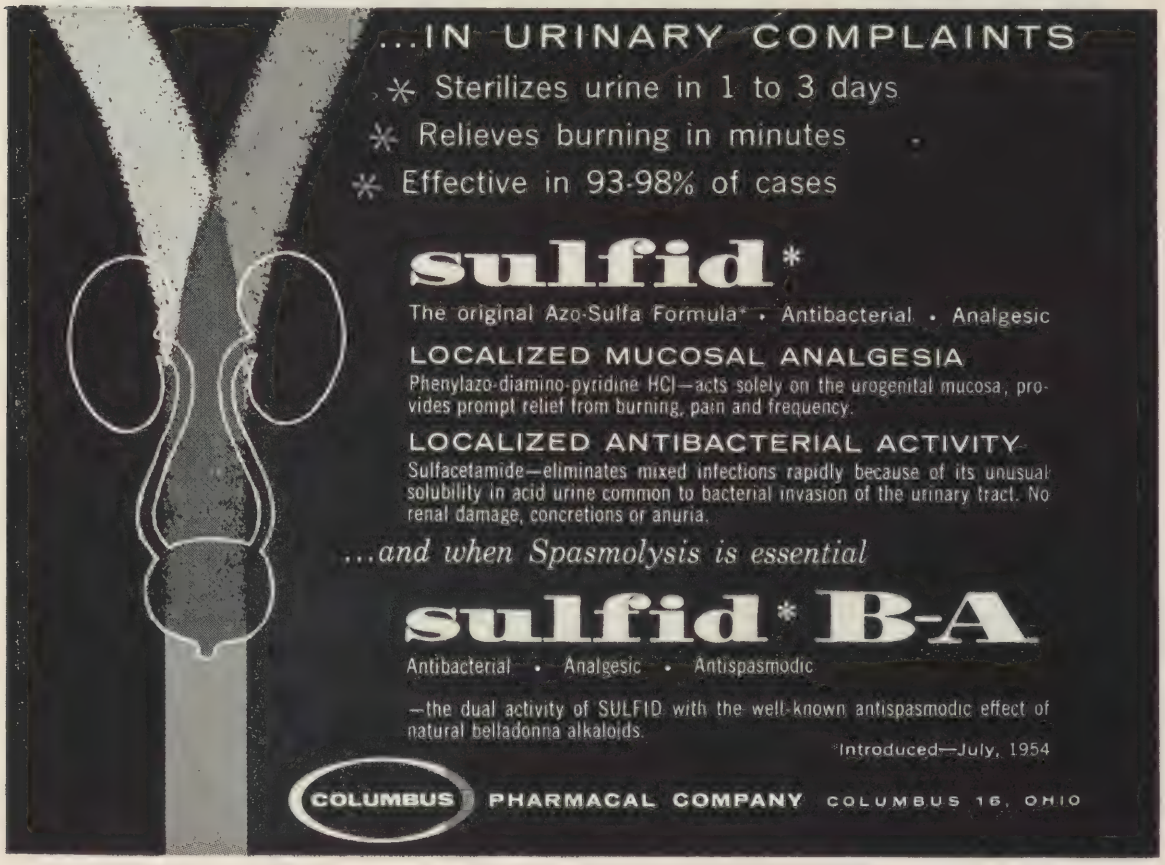
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COMING MEETINGS

1958 Annual Meeting, Ohio State Medical Association, Cincinnati, April 15-17.

American Medical Association, Annual Session, San Francisco, June 23-27.

American College of Surgeons, Course in Fractures and Other Trauma, Chicago, April 16-19.

Amercan Trudeau Society, 53rd Annual Meeting, Philadelphia, Pa., May 19-22; concurrent with meetings of the National Tuberculosis Association.

Fifth International Congress of Internal Medicine, Philadelphia, Pa., April 24-26.

1958 Industrial Health Conference, Atlantic City, N. J., April 19-25.

Medical Education Week, April 20-26.

Northern Tri-State Medical Association, Annual Meeting, May 8, South Bend, Ind.

Ohio Academy of History of Medicine, Taft Museum, Cincinnati, April 26.

Ohio State Heart Association, 1958 Annual Meeting, April 14, Cincinnati.

Pan American Medical Women's Alliance, Sixth Biennial Congress, Hotel McAllister, Miami, Fla., April 14-17.

Veterans Administration Clinical Conferences, Weekly on Wednesdays, 8:00 to 9:00 a. m., Cuyahoga Bldg., Cleveland.

Western Reserve University's Law-Medicine Center, two-day institute entitled, "The Mind: A Law-Medicine Problem," April 25-26.

West Virginia State Medical Association, Annual Meeting, White Sulphur Springs, W. Va., August 21-23.

Lithuanian-American Doctors Elect Officers for Year

The Lithuanian-American Medical Association of Ohio has announced its slate of newly elected officers for 1958. There are now 48 active members and four resident members in the organization, all members of their respective County Medical Societies, the secretary reported.

Officers are the following: President, Dr. Henrikas Brazaitis, 30515 Euclid Ave., Wickliffe; past-president, Dr. Daniel Degesys, Cleveland; vice-president, Dr. Jonas Stankaitis, Cleveland; treasurer, Dr. Vladas Ramanauskas, Cleveland; and secretary, Dr. Kazys Ambrozaitis, 2222 Central Ave., Cleveland 15.

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Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows: Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

GENERAL SURGEON, Experienced, Ohio licensed, Board Qualified, desires private practice location. Box 273, c/o Ohio State Medical Journal.

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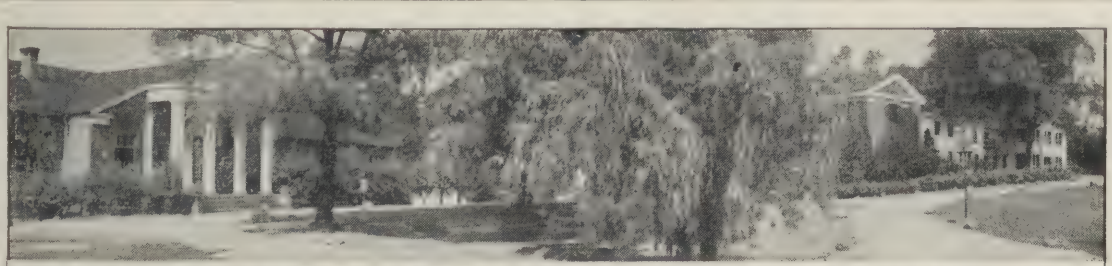
WANTED IMMEDIATELY: Assistant Physician, tuberculosis hospital, Ohio. Experience in tuberculosis preferable but not essential. Full maintenance; salary open. Box 979, c/o Ohio State Medical Journal.

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The 28th All-Ohio Safety Congress and Exhibit is scheduled to be held in the Deshler-Hilton Hotel, Columbus, April 22, 23 and 24.



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References: (1) Greenblatt, R. B., & Clark, S. L.: M. Clin. North America, Philadelphia, W. B. Saunders Company (Mar.) 1957, p. 587. (2) Greenblatt, R. B.: *J. Clin. Endocrinol.* *16*:869, 1956. (3) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* *91*:418, 1956.

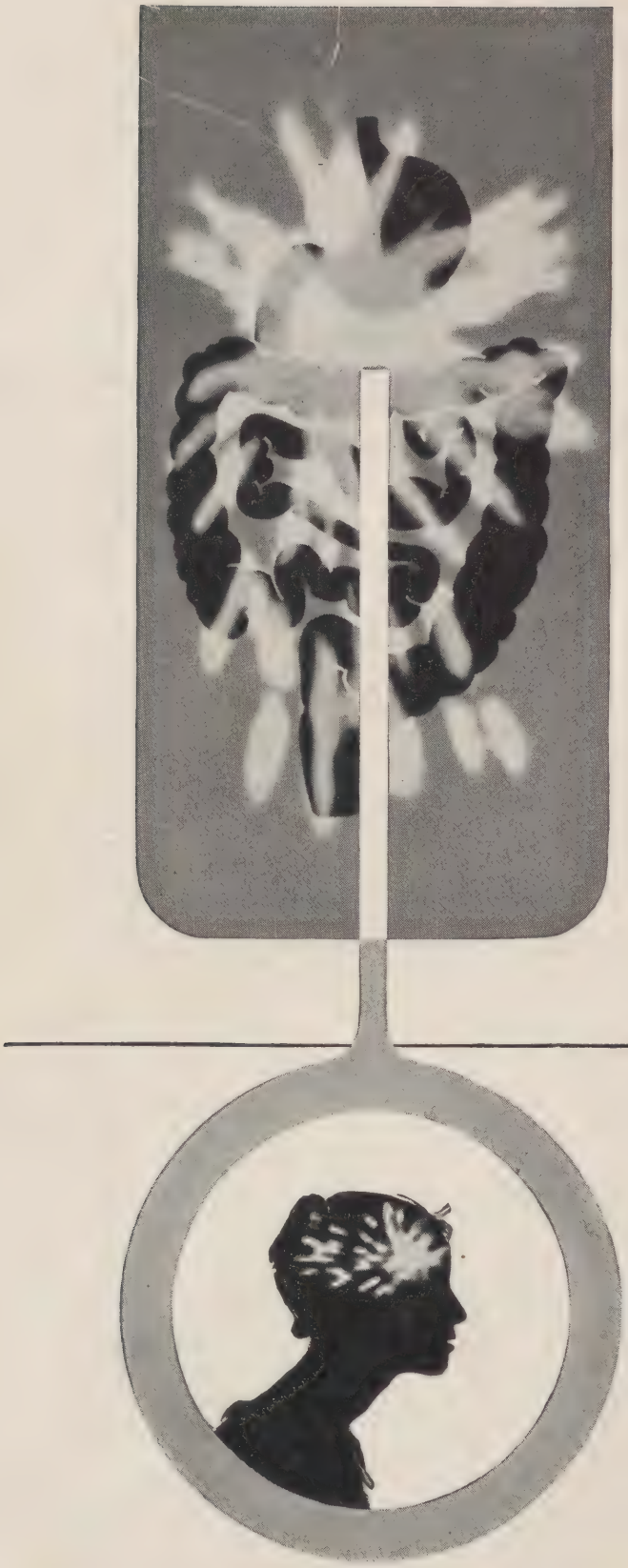
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May 1958 ★ VOLUME 54 ★ NUMBER 5

The Ohio State MEDICAL JOURNAL

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OF MEDICINE

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GLML

The Ohio State Medical Journal

Vol. 54 May, 1958 No. 5

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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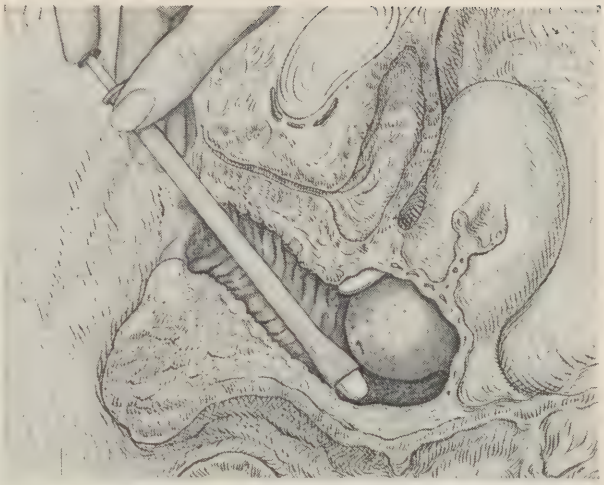
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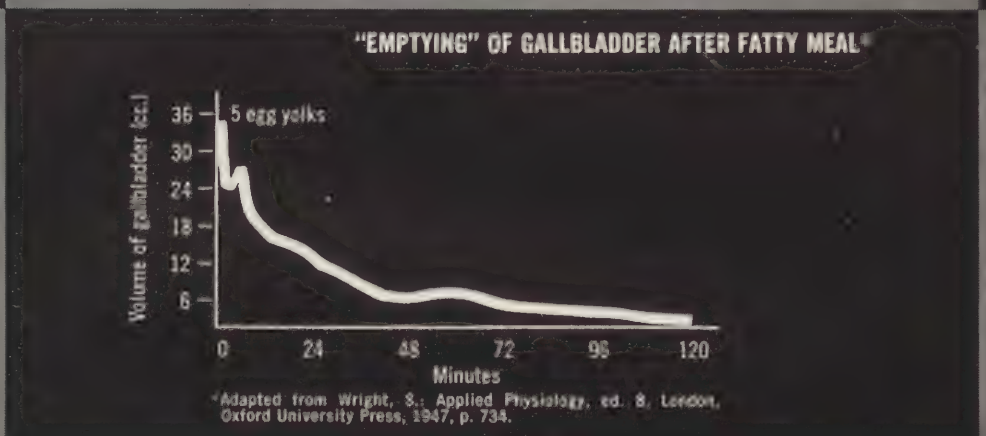
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*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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Source—Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 1177.

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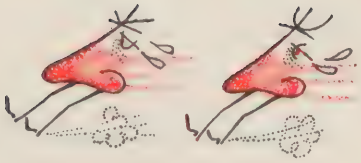
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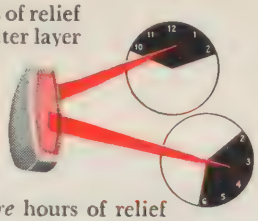
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VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

FOURTH DISTRICT

DEFIANCE—William S. Busteed, President, Defiance; Gerald A. Huber, Secretary, Defiance. 1st Saturday, monthly.

FULTON—Edwin R. Murbach, President, Archbold; Robert A. Ebersole, Secretary, Archbold. 4th Tuesday, monthly.

HENRY—Tony P. Delventhal, President, Napoleon; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday, monthly.

LUCAS—Harvey C. Gunderson, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; Robert W. Minick, Secretary, Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, Paulding; D. E. Farling, Secretary, Payne. 3rd Wednesday, monthly.

PUTNAM—Joseph J. McHugh, President, Ottawa; Will W. Moody, Secretary, Vaughnsville.

SANDUSKY—Edwin C. Swint, President, Fremont; Paul E. Burson, Secretary, Bellevue. 3rd Wednesday, monthly.

WILLIAMS—David S. Brown, President, Stryker; Harvey F. Doe, Secretary, Edgerton. 3rd Tuesday, monthly.

WOOD—Stewart J. Smith, President, Bowling Green; Richard L. Pearse, Secretary, Bowling Green.

FIFTH DISTRICT

ASHTABULA—Walter J. Brown, President, Conneaut; Robert J. Zimmerman, Secretary, Conneaut. 2nd Tuesday, monthly.

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown 3. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—David Danenberg, President, Bridgeport; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vorhies, Secretary, Scio. Meetings quarterly.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Shaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Don R. Johnson, President, Nelsonville; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

County Societies' Officers and Meeting Dates (Continued)

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Richard R. Hille, President, Marietta; Roy M. Meredith, Secretary, Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Ralph B. Burner, President, Gallipolis; George E. Files, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Robert M. Andre, President, Waverly; Mack E. Moore, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. 1st Monday after the 1st Tuesday.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Mary K. Kuhn, President, Ashley; Edward C. Jenkins, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, London; Paul G. H. Wolber, Secretary, London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd.Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Harold V. Marley, President, Ashland; Myron A. Shilling, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

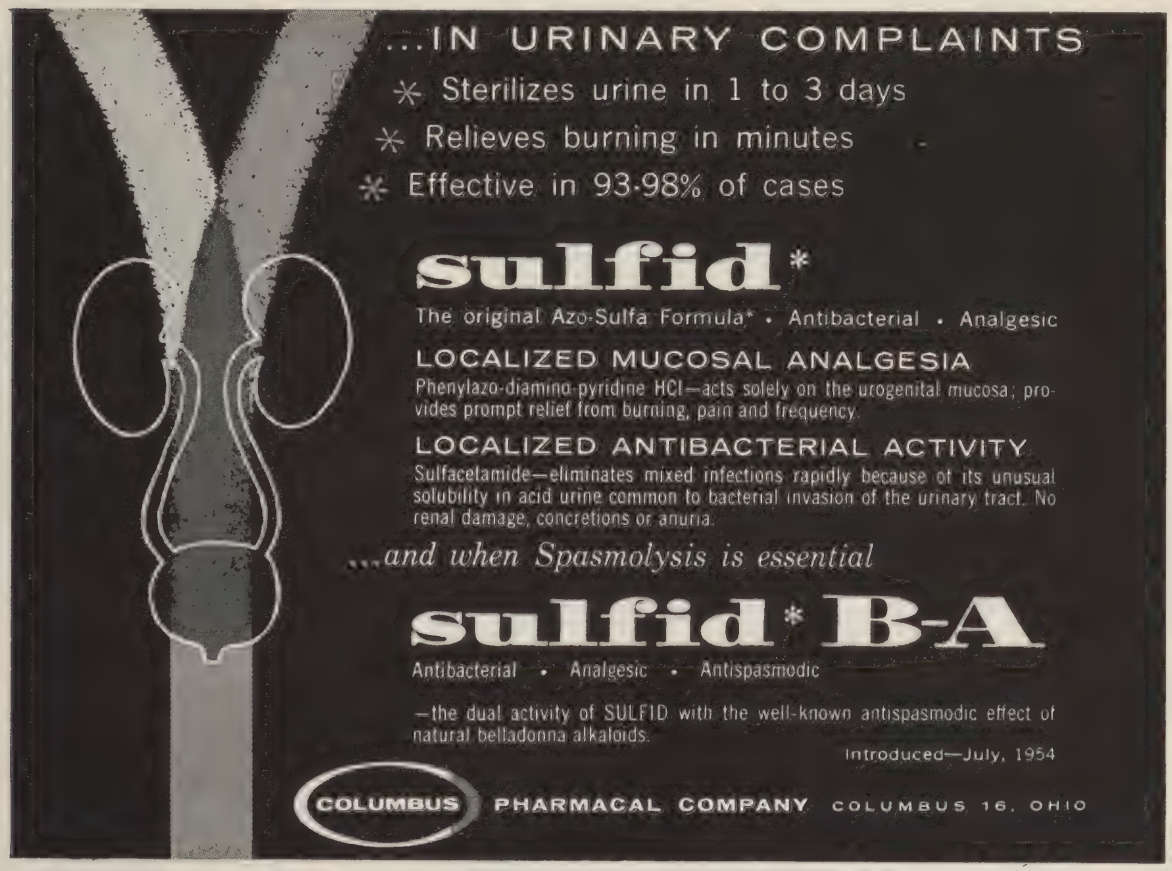
HURON—Owen J. Nicholson, President, Norwalk; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria; Mrs. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Charles F. Curtiss, President, Bellville; Harlin G. Knierim, Acting Secretary, Mansfield.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.







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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

The Fundamentals of Clinical Fluoroscopy, by Charles B. Storch, M. D. ($8.75, second edition, *Grune and Stratton, New York 16, N. Y.)* This volume gives the essentials of roentgen interpretations. In this new edition the author has expanded his text to include new methods and new facts about the subjects previously covered, plus entirely new sections on neoplastic diseases of the fundus, congenital heart disease, small bowel examinations, intestinal obstruction and fluoroscopy of the gallbladder and to all this he has added 100 additional illustrations. It is a practical and comprehensive manual fully illustrated and showing all that is needed to know about the basic diagnostic aspects of this tool.

Diseases of the Breast, by C. D. Haagensen, M. D. ($16.00, *W. B. Saunders Company, Philadelphia 5, Pa.)* This is a synthesis of what the author has learned at the Columbia Presbyterian Medical Center in New York City during the past 25 years of clinical work. When he came to the Department of Surgery there he had already acquired from Dr. Ewing and his associates at the old Memorial Hospital a deep interest in neoplastic diseases. With this background and the stimulating character of his environment at Columbia has come a wide and deep experience which has been brought into an integrated, composite picture in this excellent text.

How to Write Scientific and Technical Papers, by Sam F. Trelease. ($3.25, *The Williams & Wilkins Company, Baltimore 2, Maryland.)* The author apparently understands the problem of the beginner in scientific writing. From choosing the research problem to final proofing he all but takes you by the hand to help you over the stormy paths of composition. Every physician with the urge to write and report his work, and every physician should have this urge, will do well to have this book along with Dr. Hewitt's and Dr. Fishbein's at his elbow.

Symbols of Transformation, by C. G. Jung, ($5.00, Bollingen Series XX, by *Pantheon Books, 333 6th Ave., New York 14, N. Y.)* Volume V of the collected works of the author. This is an analysis of the prelude to a case of schizophrenia. In 1912, at the age of 37, the author published the original version of this work, which marked his divergence from the psychoanalytical school of Freud. In 1916 it was first published in England under a rather different title, **The Psychology of the Unconscious.** It has become Jung's most widely known and influential work. The author held it to be "an extended commentary on a practical analysis of the prodromal stages of schizophrenia."

The Clinical Management of Varicose Veins, by David W. Barrow, M. D. ($6.00, new second edition, *Hoeber-Harper Book Co., New York 16, New York.)* This has proved a very popular book in both the first and second editions. Now we have a revised second edition. With continued progress in the therapy of diseases of the veins, considerable revision of the text has been necessary even though the time has not been long since the second edition appeared. Diagnosis, treatment and after care of a varicose extremity are all given in an explicit fashion out of an extensive personal experience.

Men With Golden Hands—A Book of Surgical Miracles, by E. H. G. Lutz. ($3.75, *Appleton-Century-Crofts Co., Inc., New York 1, N. Y.)* This is the strange case of a little tailor with a needle lodged inside his heart; the case of a famous opera singer with pulmonary embolysm; the expectant mother; the blue baby; the overweight matron with an armor of fat around her heart; the political dictator with angina pectoris. The fate of all these rests in the surgeon's skill. Fifteen operations in all are covered. All of them are real and each one is a surgical miracle.

Surgeon in Black, by Owen M. Andrews. ($3.00, *Comet Books, New York 14, N. Y.)* This is a novel dealing with current situations and at the same time timeless as life itself. The story tells of an engineer from the Midwest and an African Negro doctor becoming very close friends. Their schooling, companionship, growth in ideals, and maturity to fine manhood make this a deeply satisfying story when integration is such a burning question. The author is a Methodist minister in the South, the son of a Confederate officer. His mother was the first woman south of the Mason-Dixon line to hold a medical degree and he himself is past chaplain of the Confederacy. This adds a great deal to the book.

Allergic Dermatoses Due to Physical Agents, edited by Rudolf L. Baer, M. D. ($3.00, *J. B. Lippincott Co., Philadelphia 5, Pa.)* Ever since W. W. Duke began to emphasize "physical allergy" there has been doubt in the minds of some

base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium metaphosphate, found [illegible]

antibacterial activity than was observed in their absence. Oil and sorbitol did not interfere with tetracycline absorption.

Dicalcium phosphate is widely used as a filler in various capsules, including those of the tetracyclines. The authors cite a large number of other studies that implicate the presence of calcium ions as the cause of the reduced absorption of tetracyclines and show that citric acid can partially neutralize this effect. The depressing effect of food on the serum levels of tetracycline is likewise explained by the goodly amount of minerals contained in commercial laboratory diets, and they postulate that the multivalent cations may be responsible for the poorer absorption of the drug. The authors could not explain the failure of citric acid to enhance serum concentrations when administered with tetracycline base in contrast to its marked effect when given as the hydrochloride. However, they hypothesized that the ability of citric acid to enhance serum levels of tetracycline is related to its ability to form complexes [illegible] available for [illegible]

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

[illegible] addendum to the last mentioned paper of [illegible] et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the [illegible] of calcium as fillers in sor[illegible] others.

[illegible] however,

Editorial.
The New England Journal of Medicine.
258:97-99, (January 9) 1958.

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as to whether it was correct to classify these cases as instances of true allergy. Rudolf and five of his colleagues attempt in this thin volume to differentiate between allergic and nonallergic hypersensitivities to physical agents.

The allergist and the dermatologist and any physician who may be interested in hypersensitivity to light, heat, cold, and trauma will profit much by the book.

Classics in Arterial Hypertension, compiled by Arthur Ruskin, M. D. ($9.50, *C. C. Thomas, Springfield, Ill.)* This monograph, the first in a series of American Lectures in Classics in Science and Medicine under the editorship of Wiktor Nowinski is dedicated to Chauncey Leake of the Ohio State University. It presents 350 pages of the most fascinating reading, showing us where we came from in our concepts and treatment of hypertension and thus where we may expect to find pay dirt in the future.

Practical Diagnosis and Treatment of Liver Disease, by Carroll Moton Leevy, M. D. ($8.50, [Hoeber] *Harper & Brothers, New York 16, New York.)* Out of the coordinated study of 1000 patients with various liver disorders comes a wealth of practical information carefully organized for the physician in clinical practice. It is a practical guide on how to correlate clinical, biochemical and hystological findings into a composite approach to liver disease. Emphasis is placed upon treatment.

Pediatric Cardiology, by Alexander S. Nadas, M. D. ($12.00, *W. B. Saunders Co., Philadelphia 5, Pa.)* It is intended as a handbook for the pediatrician, the family doctor and the medical student. The author intends to put proper emphasis upon clinical recognition and management of heart disease in children. It represents the author's experience and the experience of his fellows at the Children's Medical Center in Boston. The pediatrician, to meet the new and growing challenge of cardiac surgery in children, will find it extremely helpful. The author describes it as a "Do It Yourself Cardiology."

The Initial Management of Thoracic and Thoraco-Abdominal Trauma, by Lawrence M. Shefts, M. D. ($6.50, *C. C. Thomas Publisher, Springfield, Ill.)* In this work resuscitation is emphasized and penetrating and perforating wounds of the thorax and abdomen including injuries to the heart, the diaphragm and the esophagus. A special section of the book is concerned with the details of actual case reports, demonstrating both proper and improper management. The purpose of the text is to acquaint the general practitioner and those who are taking training in surgery with the essential facts concerning what is to be done to the patient when first seen after such injuries.

Horizons for Older People, by George Gleason. ($2.95, *The Macmillan Co., New York 11, New York.)* With the shift in population towards predominance of older people the need for adults to live a useful and productive life, especially in their old age, is a matter of growing concern to the entire community. Senior citizens have long been neglected until recent developments in the field of gerontology. Therefore, this book fills an urgent need today for some 14 million of us who are over 65 and many of whom must share their problems with us doctors as well as church leaders and social workers.

From Medicine Man to Freud: An Anthology Edited with Notes by Jan Ehrenwald, M. D. ($.50, *Dell Publishing Co., 261 E. Fifth Avenue, New York 16, N. Y.)* Sections are taken from Plato, Buddah, Frazer, Schweitzer, Freud, Jung, Sullivan and many other writers on the stories of man's battle against mental illness.

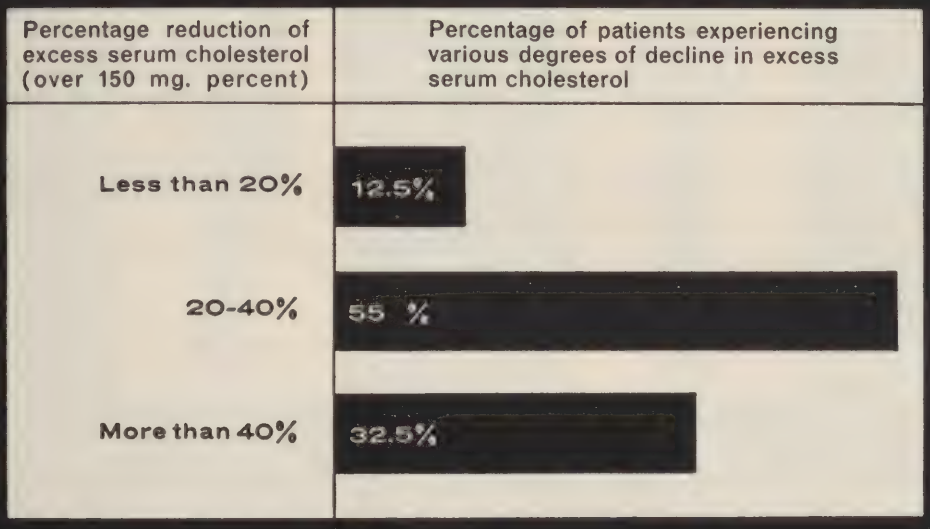
Nostalgia: A Psychoanalytical Study of Marcel Proust, by Milton L. Miller, M. D. ($4.00, *Houghton Mifflin Co., Boston 7, Mass.)* Of all the world's literary giants no one ever wrote with more insight into himself, with more painstaking attention to his own memories, dreams and fantasies than Marcel Proust. Like Freud, he investigated the unconscious mind but for literary purposes rather than scientific. In this book a distinguished psychoanalyst brings the Freudian theory to bear on Proustian art with interested and unexpected results.

The Psychoanalytic Study of the Child, Volume XI of this annual series, edited by a distinguished group of authorities. ($8.50, *International Universities Press, Inc., New York 11, N. Y.)* Divided into four sections: Theoretical Contributions; Normal and Pathological Developments; Clinical Contributions; Applied Psychoanalysis. These annuals have come to be regarded as essential reading for those who are interested in psychoanalysis of children.

Sun, Earth and Man, by George and Eunice Bischof. ($2.75, *Brace Harcourt and Co., New York 17, N. Y.)* This is an attempt to give us some understanding of the universe by telling us how our own earth came into being. The authors begin this stimulating account of man's relationship to the world and go on through from the beginning to the eventual evolution of man. The authors tell the story of man and his problems, the use of our resources presenting a tremendous challenge, raises the question of what is hid in the

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Clinical Endodontics: A Manual of Scientific Endodontics, by R. F. Sommer, D. D. S., and F. C. Ostrander, D. D. S., and Mary C. Crowley, A. B. ($10.50, *W. B. Saunders Co., Philadelphia 5, Pennsylvania.)* This contribution from the School of Dentistry at the University of Michigan is designed to serve as a visual aid in teaching and a practical guide to reference on the subject of endodontics. This involves the integration of most of the basic sciences and makes of it a valuable text.

Diabetes Mellitus: A Handbook for Physicians, by Howard F. Root, M. D., and Priscilla White, M. D. ($7.00, Landsberger Medical Books, Inc., distributed by *Blakiston Division, McGraw-Hill Book Co., New York 36, N. Y.)* This is the fifth volume in the series of handbooks for the general practitioner on diabetes and it comes, of course, from the Joslin Clinic in Boston. In it the necessary details have been carefully presented, the relationship of diabetes to general medicine, including all of the special fields of obstetrics, pediatrics and surgery. A good deal of emphasis is placed on the complications, especially the heart, the kidney, the lung. Treatment by means of diet should be a constant aid to a man in general practice.

Homosexuality: Disease or Way of Life?—by Edmund Bergler, M. D. ($5.00, *Hill and Wang, Inc., 104 Fifth Avenue, New York 11, N. Y.)* This is a very frank book on a very serious social problem and is not intended for the idly curious. The author has been in private practice as a psychoanalyst in Vienna and New York and is well known for half a dozen other books which he has written, especially for his **Kinsey's Myth of Female Sexuality.**

Florida Nurse, by Ann Rush. ($2.50, *Bouregy and Curl, New York 22, N. Y.)* The heroine here, after graduating from nursing school lands her first job because she could speak Spanish. Her work was to be with migrant Puerto Rican workers in a vegetable growing section of south Florida. Naturally, she finds a friend in the overworked Dr. Barrows and then we have the customary suspense and the usual love story.

Youth in a Soundless World: A Search for Personality, by Edna S. Levine. ($5.00, *New York University Press, New York 3, N. Y.)* The author, a clinical pathologist, trained and experienced in the problems of deafness and its effect upon personality development finds in her scientifically controlled research a significant psychological configuration among the deaf. Though reticence and a lack of self-confidence may be considered normal characteristics for the deaf child on the basis of the level of our communication with him today, the author believes that these characteristics present a challenge and a concern to those interested in the effective life adjustment of the deaf.

Coronary Heart Disease: Angina Pectoris-Myocardial Infarction, by Milton Plotz, M. D. ($12.00, [Hoeber] *Harper & Brothers, New York 16, N. Y.)* Coronary artery disease is one of the major medical problems facing our generation. In recent years our concepts have undergone radical changes. No longer is coronary sclerosis regarded with hopelessness and resignation but rather as a condition susceptible to treatment, possibly prevention. Here is, for the first time in many years, a comprehensive organized guide to the present-day knowledge and management of this disease, its diagnosis, its treatment and its prognosis.

Your Heart is in Your Hands, by Arthur King;

What You Should Know About Cancer, by Arthur King;

How's Your Eye, prepared by The Better Vision Institute;

Guide to Mental Health, by Theodore Irwin;

What You Should Know About Skin Care, by Theodore and Rita Irwin;

What You Should Know About Sleep, by Theodore Irwin.

The foregoing are some of the pamphlets produced by the *Good Reading Rack Service, Inc., 76 Ninth Avenue, New York 11.* They are designed primarily for corporations to put on reading racks for their employees. They are therefore sold in bulk at a very low cost. The minimum order is for one dollar's worth, and the price is adjusted to suit the number ordered up to 35,000 or more copies.

Mental Health in Kansas: Community Action, by Margaret Cram. (Apply. *Governmental Research Center, University of Kansas, Lawrence, Kansas.)* This is Citizen's Pamphlet Series No. 20 put out from this research center and describes mental health problems as found in Kansas and a report on what is being done about it.

Dorland's Illustrated Medical Dictionary, prepared by a long list of contributors and consultants. ($12.50, Edition 23. *W. B. Saunders Co., Philadelphia 5, Pa.)* This edition of the well-known dictionary has been rechristened in honor of W. A. Newman Dorland who saw this book through 21 editions. It has been enlarged and



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New and Nonofficial Drugs, 1958, Evaluated by the AMA Council on Drugs. ($3.35, *J. B. Lippincott Company, Philadelphia 5, Pa.)* This valuable reference book—an annual publication, formerly **New and Nonofficial Remedies,** maintains its usual high standard.

A Psychiatric Glossary. ($1.00. *Mental Health Materials Center, 1790 Broadway, New York 19, New York.)* A list of the words and their meaning as used most frequently by psychiatrists. The booklet has been prepared by the committee on Publications of the American Psychiatric Association and is therefore official.

Clinical Laboratory Methods, by W. E. Bray, M. D. ($9.75, Fifth Edition. *C. V. Mosby, St. Louis 3, Mo.)* The previous editions have been well received for the author has succeeded in producing a synopsis for ready reference of the more recent information—brought together from many scattered sources.

Expectant Motherhood, by N. J. Eastman, M. D. ($1.75, 3rd Edition. *Little Brown & Co., Boston 6, Mass.)* The Professor of Obstetrics at Johns Hopkins Hospital has revised his reassuring guidebook for the pregnant woman.

Women Doctors of the World, by Esther Pohl, Lovejoy, M. D. ($5.95. *Macmillan Co., New York 11, N. Y.)* This book contains a wealth of information regarding the work of women in medicine.

The Deeds of Dr. Deadcert, by Joan Fleming. ($2.75. *Ives Washburn Inc., New York 3, N. Y.)* A swift moving, witty tale of mystery concerning the fashionable physician at an English seaside resort, three times a widower and beloved by his elderly patients.

Heredity and Your Life, by A. M. Winchester, Ph. D. ($5.00. *Vantage Press, New York 1, N. Y.)* This is an account of everyday human inheritance by the professor of Genetics at Stetson University, Deland, Florida. This is an informative book by an expert and offers a wealth of clearly presented data that will give the prognosis-conscious American reader background for the news as it appears in the press and as it affects his life.

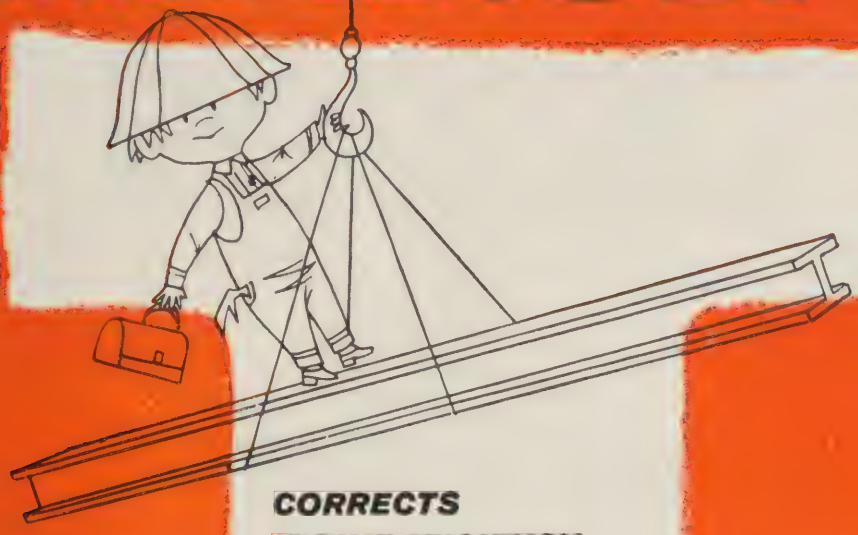
The Importance of Overweight, by Hilda Bruch, M. D. ($5.95. *W. W. Norton Co., Inc., New York 3, N. Y.)* The author received her degree from Freiberg University, specialized in biochemistry and pediatrics and then after a year in London came to the United States and became associated with the Department of Pediatrics of Columbia University. She has done postgraduate work on a Rockefeller Foundation Fellowship in Psychiatry. She is now engaged in private practice although she is associate clinical professor of Psychiatry at Columbia. In addition to her work on obesity she has contributed to pediatrics, to psychosomatic medicine and to psychiatry. Her studies on obesity have made a profound influence on the approach to this problem. In this book she presents a comprehensive and very readable discussion of the medical, biological, sociological and emotional factors involved with obesity, based on her experience of the past 20 years.

The Magic of Balanced Living: A Man's Key to Health, Well-Being and Peace of Mind, by John Tebbel, with an introduction by Alvin C. Drummond, M. D. ($3.50. *Harper and Brothers Books, New York 16, N. Y.)* As Dr. Drummond, the famous urologist says in his introduction, the casual reader will profit by this book. The author has a straight-forward approach to an often hackneyed subject. Gives the reader intelligent and well balanced information as to how medicine is helping all of us to live healthier lives, both physically and mentally. The book is written in the modern tone in terms of the total personality of man. It is much above the currently popular books on adaptation to living.

Feel Like a Million, by Catharyn Ellwood. ($3.95. *Devin-Adair Co., 23 E. 26th St. New York 10, N. Y.)* The book tells in an inspirational way how proper nutrition can revolutionize your lives. The author is a popular lecturer on nutrition. This can be a useful book and the author can be forgiven the use of the huckster's technique in selling total nutrition. Dr. Coda Martin points out in his introduction "in order to participate in this new concept of total nutrition it is necessary to have a source of sound and factual information on the subject. This book by Catharyn Ellwood who is qualified and an experienced teacher and lecturer on nutrition will serve as a guide in the choice of foods that contain optimal amounts of the essential nutrient factors."

An Outline of Bacteriology and Immunity, by Ronald Hare. ($7.00. *Longmans, Green and Co., New York 3, N. Y.)* This is for the most part a text based on a course of lectures given to the medical students at St. Thomas' Hospital in London by the professor of bacteriology of the University of London, and represents a very concise text well worth reading if one is reviewing and trying to bring oneself up to date in bacteriology and immunology.

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PARTICULARLY FOR CHILDREN



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INCREMIN Syrup

FORMULA: Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine Mononitrate (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	0.75%

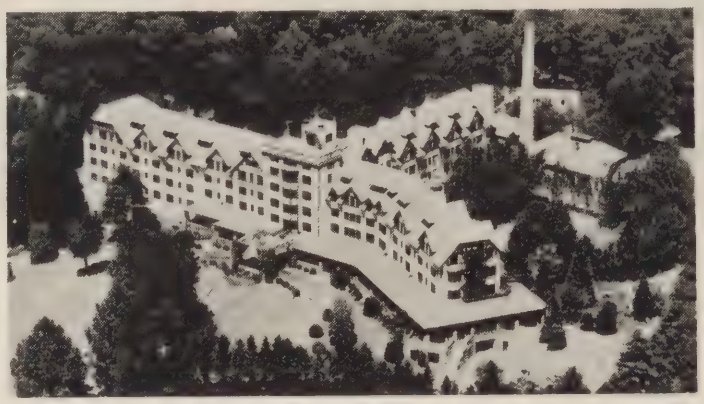
Average dosage is 1 teaspoonful daily.
Available in bottles of 4 fl. oz.

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—released in the stomach from gastric-soluble outer coating of tablet.	
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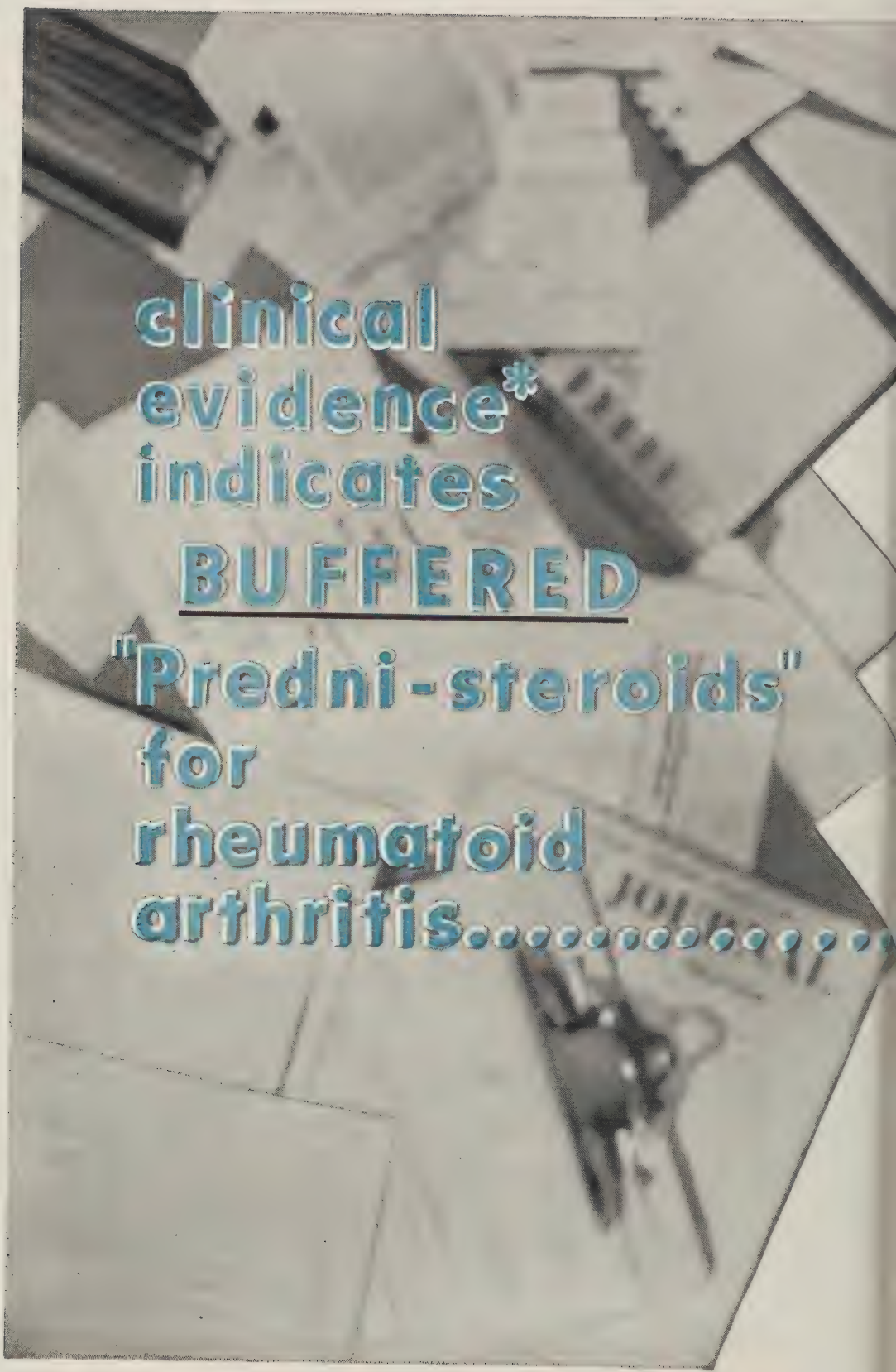
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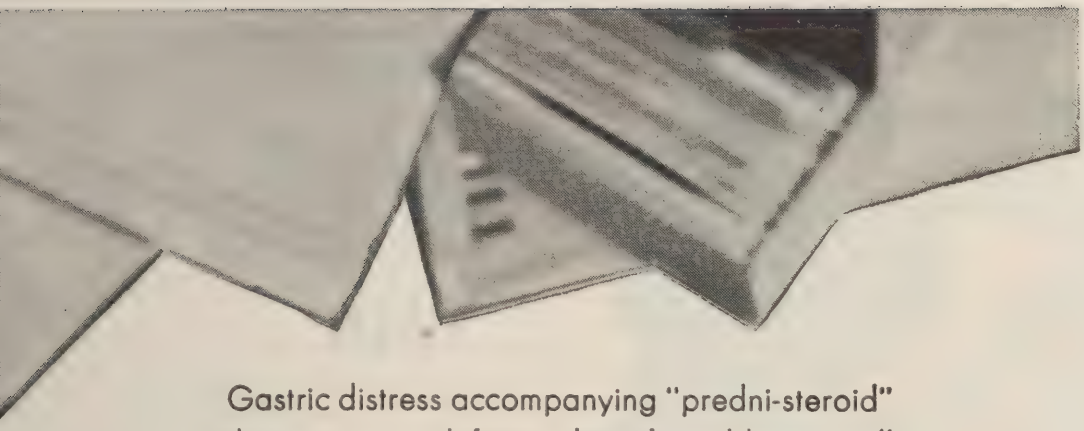
As a comprehensive supplement to deficient natural secretion of digestive enzymes, particularly in older patients, ENTOZYME effectively improves nutrition by bridging the gap between adequate ingestion and proper digestion. Among patients of all ages, it has proved helpful in chronic cholecystitis, post-cholecystectomy syndrome, subtotal gastrectomy, pancreatitis, dyspepsia, food intolerance, flatulence, nausea and chronic nutritional disturbances.

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Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem—well documented in a growing body of literature.

*"In view of the beneficial responses observed when antacids and bland diets were used concomitantly with prednisone and prednisolone, we feel that these measures should be employed prophylactically to offset any gastrointestinal side effects."—Dordick, J. R. *et al.*: N. Y. State J. Med. 57:2049 (June 15) 1957.

* It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

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provide all the benefits of "Predni-steroid" therapy—plus positive antacid protection against gastric distress

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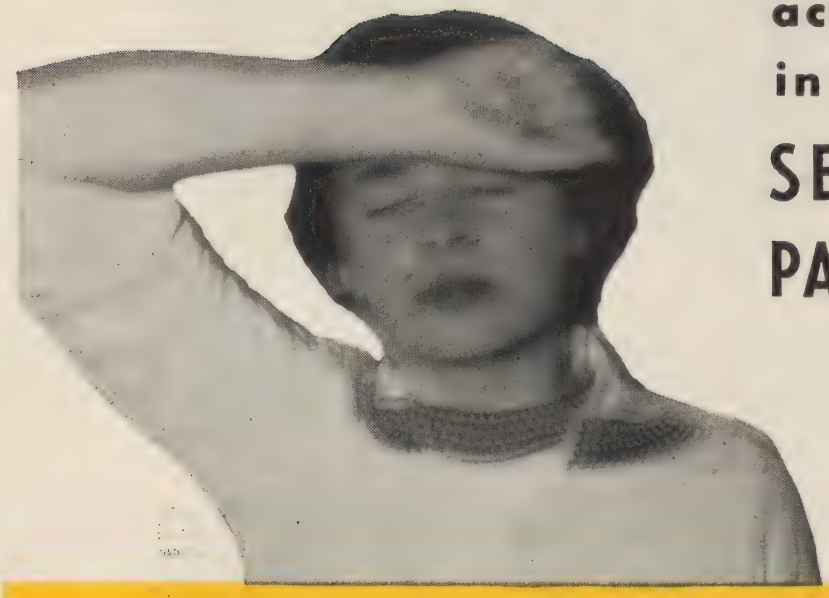
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2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. magnesium trisilicate, in bottles of 30, 100, 500.

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SUPPLIED:

VIALS, 10 cc. and 30 cc. TABLETS, bottles of 100 and 1000.

*Joseph, Morris: Effective Analgesia Without Sedation or Narcosis, Clinical Medicine, August 1957.

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Census Bureau survey recently completed shows 48.5 million Americans under age 40 have not received polio shots; 42.5 million have received three shots. Public Health Service advisory group has come up with a statement that fourth polio shot is unnecessary; final decision left to physician.

* * *

Veterans Administration has established a new division in its department of medicine and surgery to coordinate about 2,000 current VA studies of disorders of the aged, and to survey possibilities for new research in retarding physical and mental deterioration.

* * *

Evidence "that could point the way toward development of a vaccine for treatment of some types of cancer" by triggering a natural defense mechanism of the body has been reported by VA researchers, who now are looking for a way to activate this mechanism to the extent that it would destroy some types of malignant growth.

* * *

Public Health Service is working on a "progressive care" program for hospitals, a new concept for patient care having five types of programs patterned to meet the needs of the individual patient as he progresses in his illness: intensive care, intermediate care, self care, long-term and home care.

* * *

Health, Education and Welfare Director Folsom has reported that private major medical insurance coverage has increased almost 20 times in five years—from 700,000 persons in 1952 to an estimated 13 million.

* * *

Aero Medical Association has called on the Civil Aeronautics Administration to strengthen its medical department and provide the department with funds adequate for its responsibilities, which include research and supervision of fliers' periodic physical examinations.

* * *

Washington conference of National Committee on Aging (Voluntary, non-official organiaztion) brought out the following: any social security changes should await report of a committee studying the program (Folsom); "Five to 10 billion dollars more per year should be spent on older people" (Wilbur Cohen, former Oscar Ewing aide); "I am old-fashioned enough to think most of us can take care of our own needs (in old age) if we know the methods" (New York State Senator Metcalfe).

* * *

Six American women medical scientists chosen for a month tour of Russian medical institutions include Dr. Esther C. Marting, radiologist, University of Cincinnati College of Medicine and past-president of the American Women's Medical Association.

* * *

Atomic Energy Commission has awarded 40 continuation and six new contracts for investigations into the life sciences. Western Reserve University, one of two institutions to receive six-figure awards, got a $201,791 contract; University of Utah, $271,753.

* * *

Northern parts of Ohio are to be served by new Food and Drug Administration district office and laboratory to be opened in Detroit next fall. It also will serve Michigan and parts of Indiana. Total area includes 15 million population now handled by FDA offices in Cincinnati and Chicago. Staff of 67 is to include 20 scientists and 28 inspectors.

* * *

American medical care is a part of the nation's display at the World's Fair in Brussels, with the $1-million investment in medical displays expected to provide effective counter-propaganda to the more than 1,000 public health displays in the Russian pavilion.

Placement Aid Leaflet Available to Doctors

A new throw-away leaflet—"Look Before You Leap"—is being produced by the AMA's Physicians Placement Service as a check list for physicians seeking a location. Since many physicians still apparently are not aware of the placement services available to them through their state medical associations and the American Medical Association, this leaflet will be distributed in adequate supplies to state societies, hospitals and medical schools.

When tetracycline therapy is indicated—

3 INDISPUTABLE POINTS



References: 1. Council on Drugs, A.M.A.: J.A.M.A. 166:52, 1958. 2. Pulaski, E. J.: Practitioner 179:465, 1957. 3. Cronk, G. A., and Naumann, D. E.: Ant. Med. & Clin. Ther. 4:166, 1957. 4. Kaplan, M. A., Dickison, H. L., Hubel, K. A., and Buckwalter, F. H.: Ibid. 4:99, 1957. 5. Prigot, A., Shidlovsky, B. A., and Felix, A. J.: Ibid. 4:287, 1957. 6. Pulaski, E. J., and Isokane, R. K.: Ibid. 4:408, 1957. 7. Putnam, L. E.: Ibid. 4:470, 1957. 8. Rein, C. R., and Fleischmajer, R.: Ibid. 4:422, 1957. 9. Welch, H., Lewis, C. N., Staffa, A. W., and Wright, W. W.: Ibid. 4:215, 1957. 10. Cronk, G. A., Naumann, D. E., and Casson, K.: Antibiotics Annual, 1957-8, ed. by H. Welch and F. Marti-Ibanez, Medical Encyclopedia, New York, p. 397, 11. Dube, A. H.: Ibid. p. 409. 12. Hubel, K. A., Palmieri, B., and Bunn, P. A.: Ibid. p. 443. 13. Kaplan, M. A., Albright, H., and Buckwalter, F. H.: Ibid. p. 415. 14. Portney, B., Draper, T., and Wehrle, P. F.: Ibid. p. 386. 15. Shidlovsky, B. A., Prigot, A., Maynard, A. de L., Felix, A. J., and Hjelt-Harvey, I.: Ibid. p. 459.

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TO REMEMBER ABOUT

Tetrex®

THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

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1 Tetrex requires no "activating additive"

— it is purely tetracycline phosphate complex, with an inherent, chemically unique property of being rapidly and efficiently absorbed.

Each Tetrex Capsule contains:

Active ingredient: TETRACYCLINE PHOSPHATE COMPLEX, 250 mg. (tetracycline HCl activity)

Excipient: Lactose q.s.

2 Tetrex produces "peak high" tetracycline serum levels

— over 5000 human blood determinations after oral or intramuscular administration have consistently demonstrated fast, high, prolonged serum levels in patients of all ages.[3,5,6,7,8,9,10,11,12,13,14,15]

3 Tetrex has an impressive documented record of clinical effectiveness

— more than 170 million doses of tetracycline phosphate complex in 1957, with 5 published clinical reports by 9 investigators on 826 patients.[3,5,7,8,10] *Clinical evaluation:* "should probably be considered an improvement over, and an ultimate replacement for, the older tetracycline hydrochloride."[10]

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Hospital practice of infant feeding

Standard formulas for WELL INFANTS

Since age, appetite and digestive capacity vary, hospital practice favors an individualized formula for each infant.

The total daily feeding usually amounts to 2 ounces of milk *per pound of body weight*, plus 1 ounce of Karo Syrup with enough water to satisfy fluid requirements.

The newborn usually takes from 2 to 3 ounces of formula per feeding; the very young infant, 4 to 5 ounces—the daily quota yielding over 50 calories for each pound the infant weighs. The quantity per feeding should not exceed 8 ounces.

Newborns are fed at 3 to 4 hour intervals throughout the 24-hour period—the 2 or 3 A.M. feeding is discontinued after the neonatal period. In the third or fourth month the 10 or 12 P.M. feeding is discontinued, once the infant fails to awaken for the bottle. Standard but individualized formulas which constitute the hospital infant feeding regimen are shown here.

WHOLE MILK FORMULAS

Age Months	Cow's Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	Feedings in 24 Hrs.	Total Calories
Birth	10	10	2	3	6	320
1	12	13	2½	4	6	390
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

EVAPORATED MILK FORMULAS

Age Months	Evap. Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	Feedings in 24 Hrs.	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	768

ADVANTAGES OF KARO® IN INFANT FEEDING



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Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo Syrup costs 1/5 as much as expensive milk modifiers and is available at all food stores.

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The Best Tasting
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down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

POLIO SHOTS—MANY NEED THEM; OSMA POLICY ON THIS REPEATED

In a recent bulletin stating that a fourth polio shot is not deemed necessary at this time, the United States Public Health Service pointed out that about 48.5 million Americans under 40—the group most susceptible to polio—have as yet not had a single dose of Salk vaccine. A warning was appended that serious outbreaks of polio may occur this summer unless vaccination is stepped up.

Thus, it behooves all County Medical Societies immediately to launch an educational campaign within its jurisdiction, designed to urge all under 40 who have not had three polio vaccine shots to visit their personal physician at once.

The recommended policy of the Ohio State Medical Association as to immunization programs was established by the House of Delegates at last year's Annual Meeting through the adoption of the following resolution:

"WHEREAS, The Ohio State Medical Association is of the opinion that each county society should carry out immunization procedures that seem more effective for the area concerned, in the best interests of the community, and

"WHEREAS, Personal health is the responsibility of each individual, and

"WHEREAS, The state of emergency has ceased to exist, and

"WHEREAS, Certain national organizations are entering more and more into the field of medicine and offering free medicines, vaccines, and attempting to set up nationally, immunization programs other than suitable for local community conditions.

"THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association oppose mass inoculation procedures, except in epidemics or emergencies or for indigent programs, and approve of these procedures in the private doctor's office or facilities directly under his control, and

"BE IT FURTHER RESOLVED, That each county medical society re-affirm its continuing program of public education as to the value of immunization procedures relating to all diseases."

TABLOID NEWS TO BE PUBLISHED BY AMA

The American Medical Association has announced that it will soon publish a new, 16-page tabloid newspaper called *The AMA News* and that it will be distributed every two weeks to approximately 200,000 physicians.

In making the announcement, Dr. F. J. L. Blasingame, general manager of the AMA, said the paper "will bring to the attention of our members the multitude of projects and activities carried on by their association, as well as other nonscientific news of special interest to the medical profession."

The first issue of the tabloid newspaper is expected to be ready for distribution at the annual AMA convention in San Francisco, June 23-27.

This move by the AMA is designed to keep physicians better informed on social-economic-legislative matters, especially those of national importance or which may take place in other states.

The hope is, of course, that physicians will take the time to read the new tabloid. Frankly, some of the effort will be wasted unless some doctors do a more thorough job of reading it than they do other medical publications, many of which include essential news and reports which every doctor should know about.

Here's wishing the new AMA tabloid the best of luck. When you start getting it, for gosh sake, read it.

CHANCE TO HELP SOLVE WORLD-WIDE MEDICAL PROBLEMS

Every physician recognizes the constantly growing importance of his county, state and national medical societies—the three great "estates" of organized medicine in America.

Now medicine has added a "fourth estate," The World Medical Association, which, though it was founded only a little more than 10 years ago, has already earned for itself world-wide recognition as "the international voice of organized medicine."

Our American Medical Association is one of the 53 national medical associations which comprise the membership of The World Medical Association. Within the United States, some 5,500 American physicians have formed a supporting committee, known as the United States Committee of The World Medical Association. President of the U. S. Committee is Dr. Austin Smith, Editor of the *Journal AMA,* and its Secretary-Treasurer is Dr. Louis H. Bauer, who has also served as Secretary General of The World Medical Association since its founding in 1947.

The purposes of the U. S. Committee are those of W. M. A. itself: to work for the highest standards of medical care in all parts of the world; to defend and preserve the freedoms that are essential to good medical practice; to provide a forum



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You have an opportunity to play your part in this vital cause by becoming a member of the U. S. Committee of W. M. A. Annual dues are $10.00. The Committee's headquarters are at 10 Columbus Circle, New York 19, New York.

VALUABLE CANCER MATERIAL AVAILABLE TO PHYSICIANS

How individual physicians can make use of the facilities of the Ohio Division, American Cancer Society, is described in a recent letter to physicians by Dr. William H. Flynn, Youngstown, chairman of professional activities for that organization.

Physicians should not hesitate to take advantage of what the society has to offer, including material on diagnosis and treatment, information which can be used in public talks on cancer, and many films and slides, both for physicians and the laity.

In addition, physicians are being sent "CA, A Bulletin of Cancer Progress" which is full of valuable data.

The cancer society, like some of the other voluntary health organizations, is a valuable resource depository for physicians. They and their patients will benefit by putting the information to work.

"IDENTIFICATION" IS FIRST PRINCIPLE WHEN WRITING GOVERNMENT AGENCY

Thanks to the nation's press, radio and TV, "mystery mail" flowing into Veterans Administration offices has been slashed 50 per cent, the VA reports.

One in 20 letters now requires some detective work to relate it to the veteran's claim. Only a few months ago, the figure was one in 10.

The agency said the nation's press, radio and TV can be credited for the improvement because of their repeated warnings in recent months that veterans should identify their claims more fully when writing to VA.

This is a good point to remember in writing to any government agency, or in advising your patient to write. With the VA, it's full name, address, date of birth and service serial number. With any government agency, where thousands of letters are processed daily, proper identification is all-important.

WANTED: MORE COUNTY SOCIETY SPEAKERS' BUREAUS

An item in the "Around Town" column of the *Youngstown Vindicator* should make welcome reading for the program chairmen of luncheon clubs and other civic organizations in that community. Here it is: "Clubs and groups in the district who want speakers on medical subjects can get qualified Mahoning County members by calling Dr. Edward Pichette, chairman of the society's speakers' bureau." With all the various clubs that are meeting in about every town, the problem of getting good speakers is becoming more and more of a problem, as anyone knows who has had that chore. And with the increasing interest of the public in medical and health topics, this enterprising offer of the Mahoning County Medical Society should have a lot of takers. Other societies please copy!

LAY PEOPLE WANT MORE NEWS FROM MEDICAL FRONT

Medical news enjoys an unusually high readership among lay people today. It used to be thought that people just wanted to be healthy and let it go at that.

Today, things are different. People not only want to know they are healthy but also what makes them healthy. They want to know about disease and disability, causes and cures.

In 1936, one of the nation's leading weekly magazines published just two medical articles. Compare this with 1956, when the same magazine published 36 medical articles.

In that year, the magazine devoted more lines to health and medical care than to steel making or automobiles—or even food. Those articles mentioned 72 different drugs 330 times, compared with no drugs mentioned in 1936.

Today, when a physician is invited to address a lay group, or when the local reporter asks for an interview, there can be little doubt that the invitation and the interview request are sincere.

Because the people want to know, the physician can perform a service for his profession and his community by accepting such opportunities with the same sincerity in which they are presented.

BOOKLET ON HEALTH OF HIGH SCHOOL ATHLETE AVAILABLE

Here's a suggestion for county medical society School Health Committees:

Get a supply of the new AMA booklet on "Protecting the Health of the High School Athlete," from the Bureau of Health Education of the AMA or from the School Health Committee of the Ohio State Medical Association.

Then see that copies get to school officials, coaches, parent-teacher groups and other interested organizations.

Finally, give the right kind of guidance and follow-up to local efforts to put the booklet's recommendations into effect.





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skeletal muscle relaxation

ROBAXIN—a completely new chemical formulation—provides sustained relaxation of skeletal muscle spasm, without impairment of muscle strength or normal neuromuscular function . . . and with essential freedom from adverse side effects. Beneficial in 94.4% of cases tested.

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You and Your Public . . .

Telling Patient Story of What Lies Behind His Fee Is Good PR Practice for Physician

THE story of all the considerations used to arrive at a fee is one that Ohio physicians might well consider telling their patients. While this requires some of the physician's time, it is well worth the effort because the patient is enlightened on all the aspects of his case instead of the relatively few self-evident considerations.

The value of this type of education, for it is education, is well developed in an article by James Cope, executive secretary of the Ohio Pharmaceutical Association, in the December issue of *The Ohio Pharmacist* as follows:

"A True Picture"

"Recently I was at the home of one of my college professors, and during our conversation we talked about pharmacy and the problems it faces today. The professor teaches political science and is very interested in associations and the way they represent their members on legislation, before administrative bodies of government, and in practically all other phases of their activity.

"During the course of the evening we talked of pharmacy's public relations in relation to the 'high' cost of medication, and I explained the various factors which go into the price of a prescription. I told him and his wife that a drug, like every other product, has its price set by many factors— maybe by more factors than any other product.

"I explained that manufacturers last year spent over one hundred million dollars on new product research—much of which went for drugs which never reached the production stage. I said a marketed drug represents many on which research was done, but which, for one reason or another, never reached the public. In addition to the research money, much valuable time was consumed on projects never completed.

Many Factors

"I told them a perfected and marketed product must pay for itself as well as for the other products which did not reach the market stage. I also explained that filling a prescription did not consist of merely counting out a few pills and putting a label on a bottle. I explained the pharmacists' devotion to accurateness, his liability, and the fact he must stock so many different items (many quite expensive) so he will have the exact one when it is needed. I further told them a pharmacist should expect some compensation beyond the ordinary merchant's mark-up, to compensate him for his training and professional service.

"I think during the course of the conversation I mentioned other factors which go into the price of a prescription as it is finally handed to the customer. I reminded them also of the amount they had paid recently for their new car, and the relation of that sum to amounts they had paid in previous years.

"After I had finished my 'argument' both of my listeners said, 'Well, I think at least some of your members are reading the information the association has been sending out on this, since what you have said is almost exactly what we were told recently by the pharmacist in our town!' They both further stated that they had never thought of any of the reasons which were explained to them by their pharmacist for the 'high' price of medication, and that both of them were appreciative of the time he took to educate them on the subject.

"When I left their home—after what had been a rather long but very pleasant discussion—I couldn't help but hope that all pharmacists throughout the state (and the nation) would take the important time to explain to the public—their customers—the true picture of pharmacy and its relation to the price the customer pays for his drugs as their pharmacist had done for them."

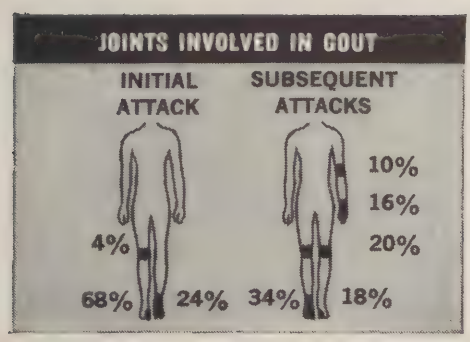
Just as the professor and his wife appreciated the "education" they received from their pharmacist, so it is entirely likely that the patient will appreciate the same from his physician.

Former AMA Official Takes "City of Hope" Post

Dr. Paul L. Wermer, who formerly served as secretary of the AMA Committee on Research and the AMA Committee on Blood, has been appointed executive medical director of the City of Hope, a 300-bed specialized hospital at Duarte, Calif. The hospital, located on a 75-acre tract east of Los Angeles, has a research institute with about 60 scientists on its staff.

Since July 1955 Dr. Wermer has been serving as vice-president and medical director of Warner-Chilcott Laboratories, Morris Plains, N. J.

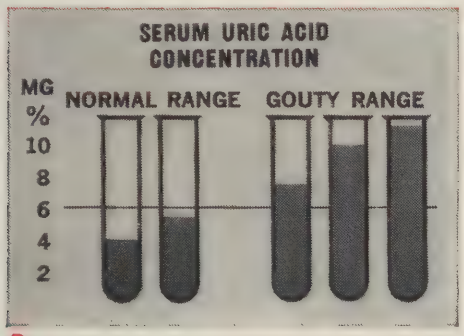
A map showing the location of Ohio's 11 district hospitals for the care and treatment of the mentally ill is available from the Department of Mental Hygiene and Correction.



1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

FROM THESE FINDINGS...SUSPECT GOUT:

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A SPECIFIC FOR GOUT

Once findings point to gout, long-term management can be started with BENEMID. This effective uricosuric agent has these unique benefits:

- Urinary excretion of uric acid is approximately doubled.
- Serum uric acid levels are reduced.
- Uric acid deposits (tophi) in tissues are mobilized.
- Formation of new tophi can often be prevented.
- Fewer attacks and severity is reduced.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

BENEMID is a trade-mark of Merck & Co., Inc.

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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Two Civil Defense Programs Are Scheduled in San Francisco

Two medical civil defense meetings will be held in San Francisco immediately preceding the American Medical Association's 107th Annual Meeting. On June 19-20, the 12th Naval District will sponsor a symposium on "Medical Problems of Modern Warfare and Civil Defense" at the U. S. Naval Radiological Defense Laboratory, and on June 21 the AMA's Council on National Defense will sponsor its 6th Annual National Medical Civil Defense Conference in the Sheraton-Palace Hotel. Dr. David B. Allman, AMA president, and Frank W. Barton, secretary, AMA Council on National Defense, will speak at the naval symposium on the plan and activities of organized medicine for medical preparedness in disasters or in the event of all-out war.

Dr. Gunnar Gundersen, AMA president-elect, will welcome participants to the AMA's civil defense meeting on June 21. The current federal civil defense program, including the national plan for mobilization of resources (personnel, facilities, supplies) will be outlined during the morning session by officials of federal governmental agencies involved. Also scheduled for the morning session will be a discussion of the threat and impact of newer weapons and delivery systems by an outstanding military planner, and a report on the legislative program now pending before congress for a national survival plan by the Hon. Chet Holifield, U. S. congressman, 19th district of California.

During the afternoon, the Surgeons-General of the Army, Navy, Air Force and Public Health Service will discuss the civil defense role and responsibilities of civilian physicians. Two other subjects to be covered include the radioactive fallout problem and the feasibility of a national shelter program.

All physicians interested in civil defense planning are urged to attend these two worthwhile meetings.

Protecting the Health of the High School Athlete

Curbing the number of unnecessary high school sports injuries and deaths is a community challenge. Physicians can provide the needed local leadership by working with school officials, coaches association, parent-teacher groups and dental society to develop adequate school health and safety programs for sports participants. One practical method—discussed in a new American Medical Association pamphlet—calls for the sponsoring of high school sports injury conferences. Purpose of these conferences is to instruct coaches, athletic directors and team physicians on the early recognition of injuries, appropriate first aid measures and the prompt referral of injured players for medical or dental care. Entitled "Protecting the Health of the High School Athlete," the booklet was prepared under the auspices of the AMA's Committee on Injury in Sports. Further information and copies of the booklet may be secured from the AMA's Bureau of Health Education.

Doctors' Wives Plan June Convention

The call of the west will be heeded by physicians' wives as they travel to San Francisco in June for the 35th annual convention of the Woman's Auxiliary to the American Medical Association at the Fairmount Hotel. National committee meetings and round table discussions will be held June 21-23 with formal opening of the convention slated for Tuesday morning, June 24. An interesting and varied program is being arranged by co-chairmen Mrs. Matthew N. Hosmer, San Rafael, Calif., and Mrs. Samuel R. Sherman, San Francisco, Calif.

Prepare Exhibits for Public Showing to Groups

The AMA Bureau of Exhibits announces that a number of new exhibits will be ready for showings by local medical societies at fairs, home shows, school and similar public gatherings this spring and summer.

"**You Can Reduce**"—shows foods to fill up on and stay away from; gives visitor an opportunity to check his weight on the scales; presents answers to pertinent questions on reducing; pictures 25 different foods and the number of calories in the servings shown.

"**Food and Nutrition Quackery**"—developed in cooperation with U. S. Food and Drug Administration, Post Office Department's fraud division,


age: 40+
insulin: 40-
"Most likely candidate
for ORINASE"
now more than
250,000 diabetics enjoy
oral therapy
ORINASE*
Upjohn
*TRADEMARK, REG. U.S. PAT. OFF. — TOLBUTAMIDE, UPJOHN

and National Better Business Bureau to point up the major false claims made in the promotion of food products and nutrition ideas; exposes house-to-house peddlers of "food supplements," nutrition and health lecturers and so-called "experts;" displays various reducing aids on a roulette wheel; features special "buyer beware" section explaining how public can recognize food quacks and their claims.

"**Breathing**"—presents the anatomy of body's breathing system and air passages and location of lungs in the body; viewer can observe how lungs expand and contract and the movement of the rib cage.

"**Glands**"—shows the location and functions of various glands in the body; presents three-dimensional models of glands.

"**Poisoning of Children**"—demonstrates dangers of common household products and depicts those products that are leading causes of poisonings in children at home.

"**Health Appraisal of the School Child**"—highlights principal health appraisal procedures, such as teacher observation, screening procedures, dental and medical examinations and the follow-through.

Survey Referral Centers For Chronically Ill

A study of five information and referral centers for the chronically ill currently is being conducted by the AMA's Council on Medical Service. Located in Chicago, Cleveland, Milwaukee, San Francisco and Essex county, N. J., these centers operate as central clearing houses for information on existing facilities for the care of chronically ill in the community. Such centers usually maintain complete information on rates, eligibility, requirements and services offered by nursing and old-age homes, chronic institutions, social service agencies, rehabilitation facilities and other services, and often carry on research to evaluate unmet needs for care in the area.

The Council's report as to how these centers operate should be of interest to physicians concerned with chronically ill patients. Any information on similar centers in other communities will be welcomed by the Council.

Pamphlet Emphasizes Driver Fitness And Suggests Check-Up

Before taking the wheel, every driver should check to make sure that he's fit to drive. Under certain circumstances—outlined in a new AMA pamphlet—a driver can be a dangerous hazard on the road. "Are You Fit to Drive?" urges drivers to contact their physicians if they are in doubt about their fitness. Prepared by the AMA's Committee on Medical Aspects of Automobile Injuries and Deaths in cooperation with the Center for Safety Education at New York University, the booklet contains information about those conditions that can adversely affect driving skills—emotional upsets, driver attitudes, sleepiness, medicines, faulty vision, certain nerve and heart disorders, diabetes, old age and drinking.

For distribution through physicians' offices, the booklet currently is available from the Association of Casualty and Surety Companies, 60 John Street, New York 38, N. Y. Price is $4.60 per 100 copies, regardless of quantity.

Plan Meeting on Labeling of Chemicals And Prevention of Poisoning

As part of an over-all program to prevent poisonings and to increase public awareness of the hazards of certain chemical products, the AMA's Committee on Toxicology has drafted a broad model law requiring precautionary labeling of hazardous substances in commercial, household and industrial chemicals. The bill is intended as a model for uniform laws to require the declaration of hazardous ingredients and warning statements on the label and in the accompanying literature of chemical products.

The first of two or more conferences with representatives of health departments, regulatory agencies, medical societies and allied health organizations to discuss this and other tentative legislation will be held May 9 at AMA headquarters, Chicago.

Physical Impairment Report Available

Reprints of a report of the AMA Committee on Medical Rating of Physical Impairment which appeared in the March 1 issue of the *Journal of the AMA* currently are available from the Council on Medical Service. The article calls attention to the substantial increase in consultative examinations being purchased with federal funds by state agencies administering the Old-Age and Survivors Insurance Disability program, lists purposes for which consultative examinations may be authorized and contains a roster of state medical consultants and reviewing physicians as listed by the Bureau of Old-Age and Survivors Insurance.

Review of Films on File May Be Ordered Now

The ninth annual *"Reviews of Medical Motion Pictures,"* containing all film reviews published in the *Journal of the AMA* during 1957, now is available from the AMA's Film Library.

COMPREHENSIVE CONTROL OF CONSTIPATION

PROVIDES SOFT STOOLS GENTLY STIMULATED TO EVACUATION

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★ prevents fecal dehydration and gently stimulates the lower colon in functional constipation

★ synergistically provides, with a subclinical dosage, peristaltic action on a soft, "normal" intestinal content rather than on the hardened mass typical of constipation

★ results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

Doxinate with Danthron (Doxan) is supplied as brown, capsule-shaped tablets containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. 1,8-dihydroxyanthraquinone.

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Doxinate is a registered trademark of Lloyd Brothers, Inc.

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(CHLOROTHIAZIDE)

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EDEMA



Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

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- Promotes balanced excretion of sodium and chloride—without acidosis.

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Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

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HYPERTENSION



1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

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The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION

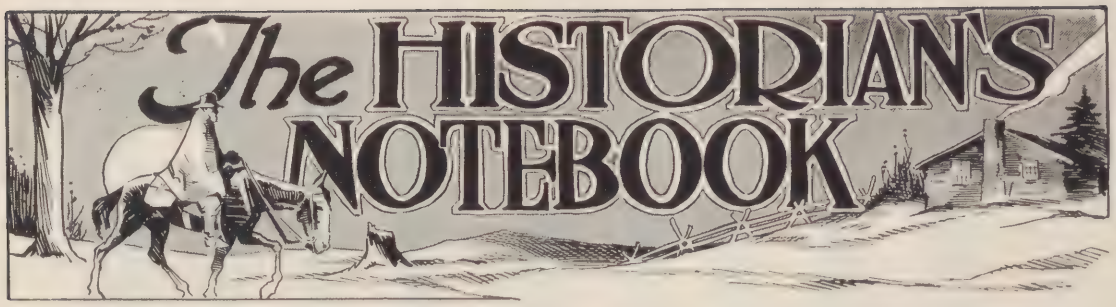
The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

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Smooth, more trouble-free management of hypertension with 'DIURIL'



Dr. Frederick C. Waite's Correspondence With Reference to Grave Robbery*

LINDEN F. EDWARDS, Ph. D.

PART II

(Concluded from April Issue)

Popular Opposition to Dissection

IN replying to a letter of mine in which I outlined to him a manuscript I was working on with reference to Grave Robbing in Ohio, Dr. Frederick C. Waite very kindly furnished me with the following pertinent information: "I presume you are aware that the antipathy of the laity to dissection, the basis of furor at grave robbing, had two primary causes. The first and oldest was religion. The second was the supposed injury to a person's reputation by having his body dissected.

"The religious feature can be traced back to the religion of early Eygpt. It was believed that the entrance to heaven could not be secured if there was any part of the body missing. Therefore if a person had an appendage missing at death a crude artificial arm or leg was carved out and attached to the corpse. This even extended to carving a wooden substitute for a missing tooth, often covered with gold foil, and inserted after death. This 'perfection' of the body was mixed with another belief, that the soul returned periodically, occupied the body and walked abroad among familiar haunts. When a body was mummified it was necessary to eviscerate it, but the viscera were put into Canopic jars and placed beside the mummy case so that when the soul returned he could put his viscera into his body before he took his walk abroad.

"The Christian religion copied many things from the Egyptian religion and one of these was that the body could not be resurrected unless it was complete and all buried in one place. The catholic church took a definite stand against human dissection because it would prevent the resurrection of the body, since the 'perfection' of the body would be ruined by dissecting it. Therefore dissection was made a capital crime in the church bringing excommunication to any who did human dissection. In some places it was a capital civil crime bringing the death penalty. More often the capital civil crime applied to desecration of sepulchre, that is grave robbing.

"Out of this evolved another procedure, Capital criminals were hung in chains and drawn (i.e. eviscerated) and quartered and the parts buried in different places which prevented resurrection according to current belief. After the drawing and quartering abated it was customary in sentencing a criminal to death, in case of heinous crimes, to add the additional sentence that his body should be dissected and thus he was denied resurrection. This dissection as an additional sentence prevailed in the American colonies.

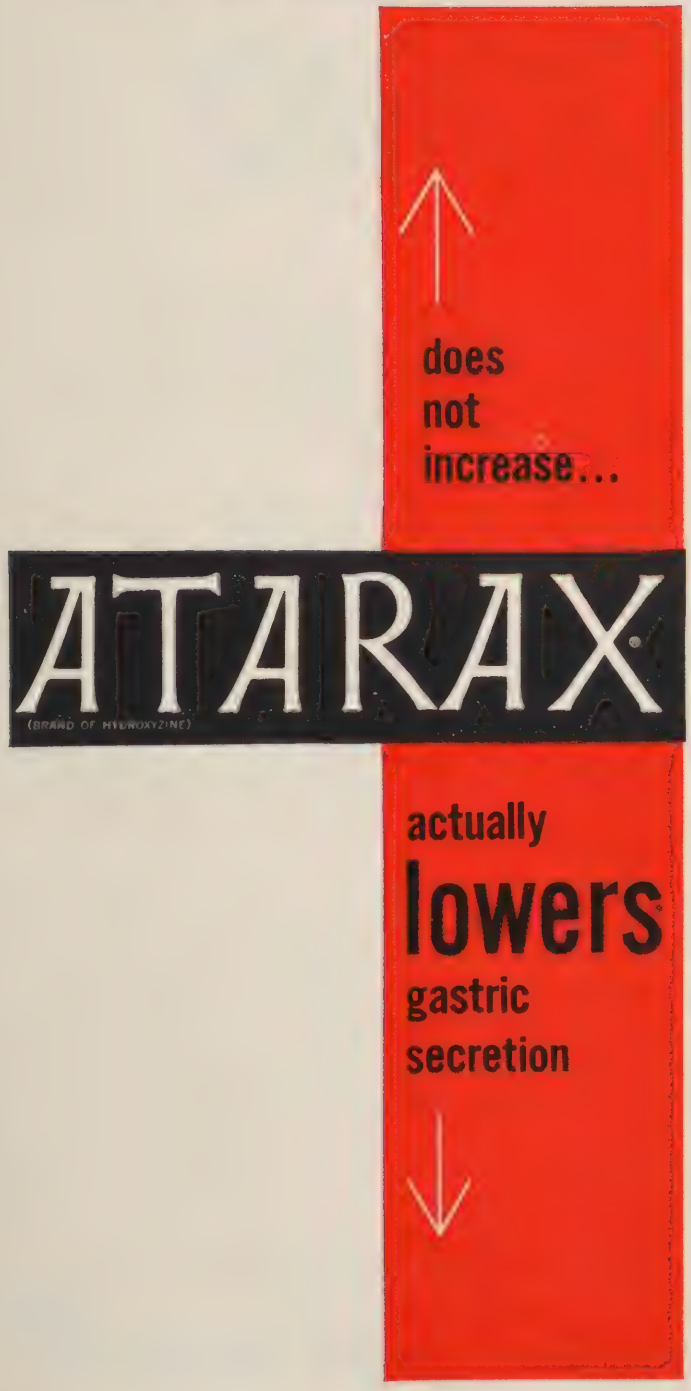
"Another way to prevent resurrection was to drive a stake through the body after it was put in the grave, a method applied to witches and duelists. For suicides, resurrection was prevented by putting a huge pile of stones on the grave. Grave robbing was a capital crime in the colonies for a time directed against those who opened a grave to get parts of the body, such as a finger or an ear, to use in sorcery. Thus dissection came

*A paper read at the Fifth annual meeting of the Ohio Academy of Medical History, Cleveland, Ohio, April 26, 27, 1957.

The Author

● **Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.**

there is one tranquilizer clearly indicated **in peptic ulcer...**



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3. It is effective in 9 of every 10 tense and anxious patients.
4. Five dosage forms give you maximum flexibility.

supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

Roerig
New York 17, New York
Division, Chas. Pfizer & Co., Inc.

to be associated with grave crimes being imposed as an additional penalty and it was believed that anyone who had his body dissected was therefore branded as a grave criminal and his reputation after death deteriorated."

Some Personal Experiences

In his inimitable manner Dr. Waite then proceeds to enlighten me with some personal experiences related to grave robbing. He writes, "I was born and grew up in Hudson, Ohio. Our place of 20 acres surrounded the cemetery on three sides, so as a boy I had no fears of the cemetery. In June 1886 a prominent man died in Hudson. The people of that town feared grave robbing since we were only 26 miles from Cleveland where there were three medical colleges.

"The man who usually took the job of watching the graves for 10 days after burial was sick and I got the job watching this grave in June 1886. I did this for 10 nights with a shotgun across my knees and was paid $5.00 per night, which was a lot of money for me who was quite willing to hoe corn or work in the hayfield for 50c a day. This $50.00 permitted me to buy a lot of new clothes for my graduation from high school in that month. I now know that the family wasted their money because the medical colleges were not in session, and hot weather precluded grave robbing in the era before embalming. Grave robbing was restricted to the months when the weather was cool, from October to April.

"In 1888 an owner of a farm adjacent to one that we owned, and located 22 miles from Cleveland was about to sell his farm. It contained a family burying ground distant from the farmhouse and was surrounded by an iron fence containing seven tombstones and graves, all of adults. The dates were from 1860 to 1880. The owner wanted to remove the bodies from this private cemetery to the town cemetery before he sold his farm. My brother and I took the job of this removal.

"In five of the graves we found no bones. The only two that had bones were of those people who had died in summer months. This cemetery, 22 miles from Cleveland, was just within the limit of grave robbing for the medical colleges of that city. Rarely were graves robbed for medical colleges beyond 25 miles, which was about as far as a team could be driven in darkness and get back. This is an example of the fact that family cemeteries in the country were favorite sources of cadavers. The chief deterrent was barking dogs if the cemetery was near the farmhouse.

"In 1911 Dr. C. A. Hamann, our professor of anatomy, resigned after 17 years of teaching. I was appointed one of a committee of three to find a successor. Several names were suggested and I was appointed to visit the institutions where these men were teaching to get firsthand information. Among the institutions I visited was [omitted]. There I found that the cadavers used were all Negroes and came from Tennessee, where some men were employed to resurrect bodies, put them in oil barrels in formalin and ship them to the [omitted] Company which was the name under which the professor of anatomy posed. These cadavers cost about $50.00 each when received.

"Meanwhile, a half mile distant the bodies of all who died in the state hospital were buried in quicklime so that they could not be used for dissection. This shows the lack of correlation" [I'm sure he meant cooperation] "between different state institutions. If you use this in publication I think the name of the institution had better be omitted."

Competition for Cadavers

Here is another interesting story: "In 1879 the body of a prominent man who died in a village near Cleveland was removed from its grave. The demonstrators of anatomy at all three medical colleges were arrested and thrown into jail. They were released the next day on a fine of $5.00 each although it was not determined which one was guilty. This is authentic. It was told me by Dr. William T. Corlett, who died a year ago," (this letter was written on April 30, 1949) "in Cleveland at the age of 94. He said he knew because he was one of the three that were jailed. He was demonstrator of anatomy at Wooster Medical College. He said he did not get that particular body but gladly paid a fine of $5.00 to end the matter. The two that were not guilty of this resurrection obtained from the third man, connected with the homeopathic college, the confession that he got the body.

"There is another condition of interest. There was competition for bodies, and there was an agreement between demonstrators of anatomy of competing medical colleges that the group that first reached a grave had priority and that if another group came they should retire. In 1885 a man died in Bainbridge, 12 miles from Cleveland. The group from the Western Reserve University Medical School had reached the grave and started digging when the group from the homeopathic school arrived. They were drunk and instead of retiring started to fight. When they were knocked down, they got into their conveyance and started through the town yelling 'your graveyard is being robbed'. This brought out the citizens and the Reserve group had to flee without getting the body. This was told me by one of the homeopaths who was drunk."

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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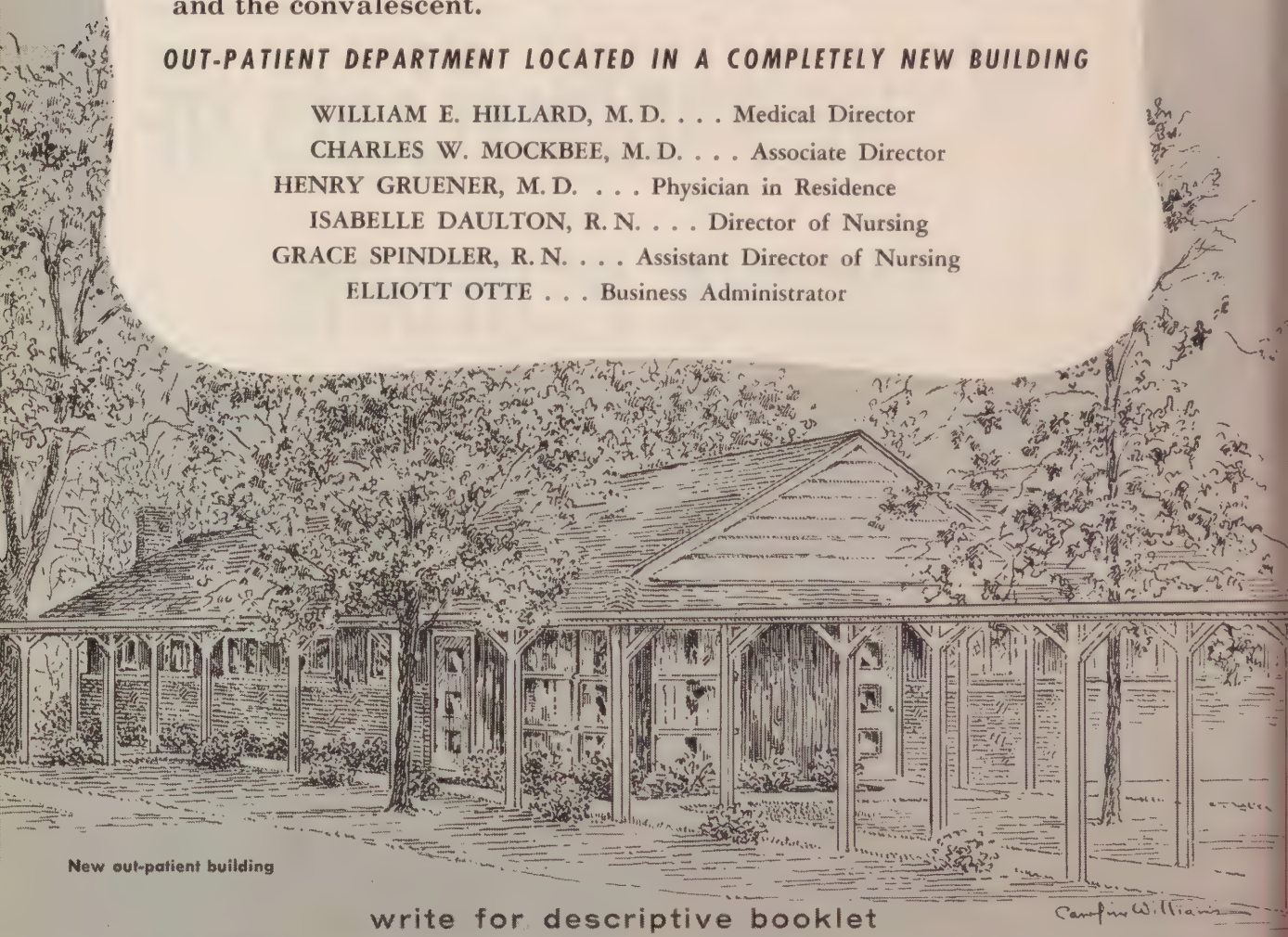
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...from moderate to severe pain complicated by tension, anxiety and restlessness.

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...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

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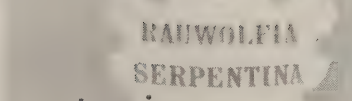
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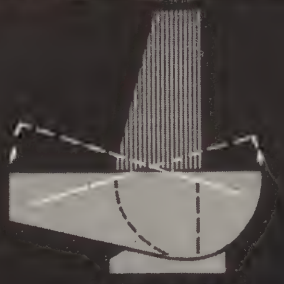
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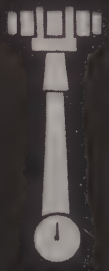
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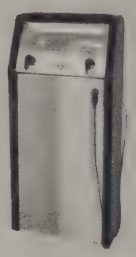
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(1) Noojin, R. O.: South. M. J. 49:149, 1956. (2) Goldman, L.; Flatt, R., and Baskett, 25:75, 1955. (4) Frank, L., and Stritzler, (5) Robinson, R. C. V., and Robinson, (6) Canizares, O.; Shatin, H., and Rosen 1955.

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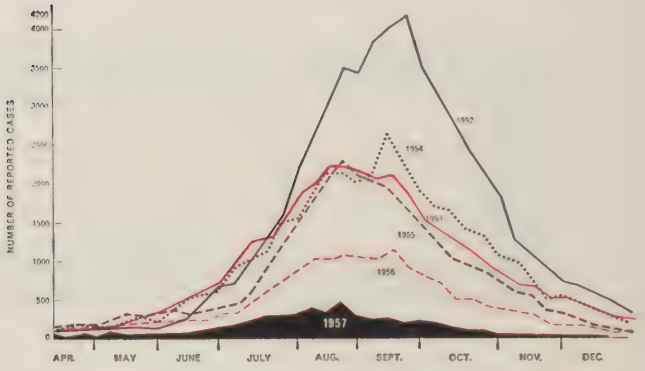
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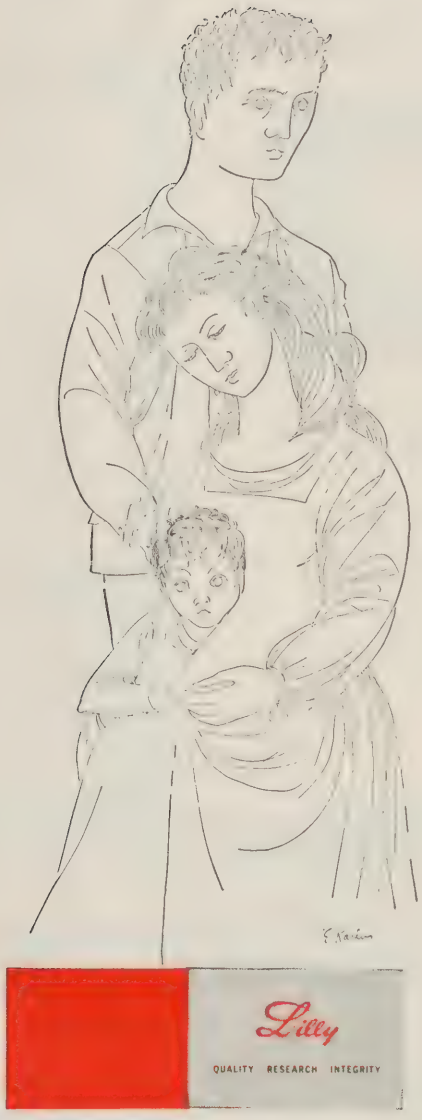
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1. *J. A. M. A.*, 165:21 (*November 23*), *1957.*
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*



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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 54 May, 1958 No. 5

JONATHAN FORMAN, M. D., *Editor*

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The Incidence of Pulmonary Fungus Disease (1951-1956) At the Ohio Tuberculosis Hospital

FRED G. CONRAD, CAPT. (MC), USAF, and ROBERT J. ATWELL, M.D.

DURING the five years, 1951-1956, seventeen cases of pulmonary fungus disease have been diagnosed at the Ohio Tuberculosis Hospital. A brief discussion of the types of pathogenic fungi found in Ohio during this period and the manner of diagnosis and treatment of the disease they produce would be profitable since this is evidently not an uncommon disease. There were 1,370 patients admitted and 219 were ultimately discharged as having nontuberculous disease. Of this number, 7.7 per cent had pulmonary fungus infections.

The Authors

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Histoplasmosis

Histoplasmosis is a systemic disease and can cause a variety of signs and symptoms such as fever, emaciation, anemia, leukopenia, ulceration of mucosal surfaces, cough, sputum, pleuritic chest pain and reticuloendothelial involvement with hepatosplenomegaly and lymphadenopathy.[1,2]

The diagnosis may be established by culture of sputum, gastric washing, bronchoscopic aspiration, blood, bone marrow, and tissue biopsy. Serologic tests of complement fixation and collodion agglutination are relatively simple, accurate, specific and are diagnostic when positive in titers of 1 to 40 and 4 plus at 1 to 10 respectively. A negative tuberculin skin test and a positive histoplasmin skin test in the presence of signs, symptoms and x-ray suggestive of tuberculosis, may be considered diagnostic as histoplasmosis in Ohio.

On roentgenograms, pulmonary histoplasmosis may produce interstitial pneumonia, discrete or confluent areas of pneumonia, miliary disease, chronic granulomata, caseation, abscess formation, fibrosis, calcification and cavitation.

Unfortunately there is no treatment for histoplasmosis, and surgery tends to spread the disease and increase its activity.

Nine patients were diagnosed as having pulmonary histoplasmosis. The major symptoms were easy fatigability, weight loss, fever, productive cough and chest pain. None of our patients were anemic, only three had lymphadenopathy, two had leukopenia, one had hemoptysis and one had hepatomegaly. The diagnosis was established by sputum cultures on two, tissue cultures on two, tissue examination on one, serologic studies on one and by positive histoplasmin skin test on three patients with negative tuberculin tests. Two-thirds of the patients had cavitary disease by x-ray, and all had the disease in the upper two-thirds of the lung fields.

Blastomycosis

Blastomycosis produces a variety of lesions ranging from a subclinical infection conferring a posi-

tive skin test, to a benign self-limited cutaneous lesion, or a more severe indolent skin ulceration which spreads slowly and lasts for several years, or an acute disseminated fatal infection involving lungs, bone, skin, reticuloendothelium, genitourinary tract, and central nervous system. There is no evidence for man to man transmission, nor has an endemic area been found for this fungus.[3]

The presenting symptoms are pulmonary (50 per cent) with a hacking cough, purulent sputum, chest pain, fever, dyspnea and occasional hemoptysis; subcutaneous nodes or abscesses (23 per cent) and cutaneous lesions (19 per cent) which present as a papule, then pustule which breaks down and spreads very slowly with a raised verrucous border and a thin, atrophic central scarred area.[4]

The diagnosis may be established by sputum culture, (25 per cent) bronchoscopy, blood and bone marrow culture, or tissue culture. The skin test is positive in 50 per cent of the patients, and the complement fixation is positive in 53 per cent, but 82 per cent of the patients have one or the other positive.

In cases of pulmonary blastomycosis, the roentgenogram usually shows irregular masses extending from the hilum. The process often involves the ribs by direct extension and the lesions almost never calcify.

The treatment for the cutaneous lesions is high doses of potassium iodide after vaccine desensitization. Intravenous 2-hydroxy-stilbamidine for three to four consecutive weeks is the treatment of choice for systemic and pulmonary blastomycosis. This drug causes damage to the trigeminal nerve in a high percentage of patients. Surgery is contraindicated for pulmonary lesions since it often leads to rapid dissemination.

Two cases of blastomycosis have been diagnosed, one patient of which had prolonged hoarseness unresponsive to antituberculous therapy for several months. A biopsy of the vocal cords finally established the diagnosis microscopically. The other patient had a 15 year history of chronic productive cough, hemoptysis, easy fatigability and weight loss. He had previously had a persistent ulceration behind his right ear which finally cleared on potassium iodide treatment. This patient's diagnosis was established by pulmonary biopsy. Both were treated with intravenous 2-hydroxy-stilbamidine.

Coccidioidomycosis

Coccidioidomycosis is an endemic disease of southwestern United States. The fungus has been found in the soil on numerous occasions and is known to be harbored in many small animals and rodents in the endemic areas.[5] Seventy-five per cent of persons infected remain subclinical, but the other 25 per cent manifest the primary disease consisting of an acute, benign, self-limited upper respiratory infection with malaise, cough, sputum, fever, chest and joint pain. Twenty per cent of the symptomatic patients develop erythema nodosum. Rarely (0.2 per cent) the disease progresses to a severe, fatal, disseminated granuloma.

The diagnosis may be established by the cultures of any purulent exudates. Cultures of the fungi are dangerous to laboratory workers and should be confined to sealed Petri dishes or specially equipped laboratories. Inoculation into guinea pigs is relatively safe and a positive reaction is an orchitis in 10 to 30 days. The skin test becomes positive in only 7 per cent of the asymptomatic primarily infected group, but it is 92 per cent positive in the symptomatic patients. The precipitation test is positive in 76 per cent of symptomatic patients and the complement fixation test is positive in 55 per cent of patients with active disease.

The roentgenograms show diffuse parenchymal infiltration and hilar adenopathy which is pathognomonic if it increases as the peripheral infiltration decreases. The infiltration often leaves residual thin walled cavities (35 per cent) predominantly in the midlung fields, coin lesions, or unresolved pneumonia.

The treatment is still unsatisfactory but ethyl vanillate appears to be best and is usually used in combination with diethylstilbestrol, methyltestosterone, or sodium cinnamic acid. Amphotericin B has recently been used and may hold some promise as a therapeutic agent. Pyribenzamine® is useful when erythema nodosum is present. General supportive measures with bed rest are still the most important therapy. Surgery is indicated in cases of residual cavity since the disease does not spread after surgical intervention.

We had one patient with coccidioidomycosis. His symptoms were persistent cough, weight loss, easy fatigability, chest pain and hemoptysis. He had spent eight years in the southwest. He had a cavity in the left upper lobe which was resected and the culture grew out *Coccidioides immitis*. He has subsequently done quite well without medication.

Aspergillosis

Aspergillus fumigatus has a world-wide distribution and is found predominantly attached to grains. In man the fungus is usually a saprophyte superimposed on a primary pulmonary disease such as carcinoma, tuberculosis, asthma or bronchiectasis, but it may occasionally be pathogenic in itself. Repeated massive exposure is required to produce infection.[6] Elimination of other underlying dis-

ease should be accomplished before making a diagnosis of aspergillosis.

The symptoms are manifested predominantly in two ways: (1) a benign, superficial catarrh similar to bronchitis, and (2) a severe chronic granulomatous infection with caseation. The pulmonary symptoms are chest pain, cough with dark sputum, weight loss, anorexia, dyspnea, fever, weakness and rarely hemoptysis.

The diagnosis is almost always made by multiple positive sputum cultures. Occasionally bronchoscopy and biopsy tissue cultures are necessary. There is no routine skin test or serologic test. An antigen made from the patient's fungus may be used to determine hypersensitivity; i. e. a positive skin test.

The roentgenograms usually show a bilateral, apical, scattered infiltration of dense, smooth nodules and frequent cavitation. Occasionally there is a lobar pneumonia and pleural reaction.

The treatment consists of high doses of potassium iodide, which may be supplemented with intravenous sodium iodide, but neither of these should be used until desensitization with the autoantigen has been started. Surgery often causes an increase of the symptoms.

Four cases of aspergillosis were diagnosed in this series. The presenting complaints were productive cough, fever, chest pain and hemoptysis. All four had cavitary disease, three of the patients had several positive sputa and one had a positive culture from a tissue biopsy. All four had pulmonary resection; three patients developed empyema due to the fungus and required further corrective surgery. All received potassium iodide without much benefit. Three of the four had aspergillosis superimposed on either asthma, tuberculosis or bronchiectasis.

Geotrichosis

Geotrichum is usually a benign saprophyte frequently found in sputum, gastrics and normal stool cultures (29 per cent). Occasionally it may be pathogenic, particularly after tuberculosis or Friedlander's pneumonia. Clinically it presents as a thrush-like benign oral lesion or a chronic bronchitis with thick gelatinous sputum and occasional hemoptysis, or a severe pulmonary disease simulating tuberculosis with fever, tachycardia and cough. It may also be an enteric pathogen with diarrhea, melena, abdominal pain and superficial mucosal ulcerations.

The diagnosis is usually established by culture of sputum on Sabouraud's media. Roentgenograms show dense, patchy infiltrations with occasional thin walled cavities.

The treatment of the thrush-like manifestation and the interstitial involvement is oral gentian violet. The treatment for the bronchial and pulmonary disease is large doses of potassium iodide.

One patient was diagnosed as having geotrichosis. His symptoms were a chronic productive cough, weight loss, easy fatigability, afternoon fevers and chills. X-ray showed biapical fibrocaseous involvement with nodules and calcifications. Seven sputum cultures grew the *Geotrichum* and the patient was placed on potassium iodide but continued to get progressively worse and at last report had a large upper lobe cavity.

Summary: A brief description of the signs and symptoms, mode of diagnosis and treatment of the various fungus diseases diagnosed during the past five years at the Ohio Tuberculosis Hospital is presented. Of the nontuberculous patients 7.7 per cent had fungus infections. It should be emphasized that numerous and varied cultures should be obtained, skin tests applied and serologic studies obtained if fungus disease is suspected.

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Study of Nucleic Acids Yields Significant Findings

Viral investigation has developed another technic which has proved extremely valuable. Formerly tissue cultures were so overcome by secondary invaders that the virus under study was either destroyed or obscured by invading micro-organisms which could not be controlled. The use of some of the newer antibiotics now makes it possible to grow pure virus cultures without contamination.

In the renewed investigation of viruses, chemistry has not been neglected and is yielding important findings. The study of nucleic acid has been especially rewarding. It has been reported by Dr. Wendell M. Standley that a virus could be broken down into many protein and nucleic acid sub-units and that these could be re-assembled to form the large biologically active virus once again. Dr. Standley further states that the elucidation of the study of nucleic acid in all its aspects is the most important scientific problem we face today.—O. S. Philpott, M. D.: *Rocky Mountain M. J.*, 55:63, March, 1958.

Bromide Delirium, a Forgotten Psychosis

J. M. WITTENBROOK, M. D.

Introduction

IN this, the age of anxiety, relief from nervous tension is constantly being sought. Alcohol and the barbiturates have been popular remedies. Tranquilizers are freely prescribed in their many forms. The tranquilizers, however, must be obtained on prescription and most states now require a prescription for the barbiturates. Patent medicines which are described as tranquilizers have not been too effective.

Bromides are very effective in relieving anxiety and can be easily obtained without prescription in various forms including: Bromo-Seltzer®, BC® Powders, and Stanback®. We might expect to find many neurotic individuals turning to the bromides for relief of nervous tension, completely unaware of the dangers of this medication.

During the year of 1956, I discovered four unsuspected cases of bromide intoxication among my own private patients. This number, while not great, is nevertheless significant and suggests the probability that a considerable number of cases of this condition are undiagnosed each year.

Frequency of Bromide Intoxication

Max Levin in an analysis of first admissions to a state hospital between 1931 and 1939, found 3.2 per cent had bromide intoxication.[1] Since the four patients included in this study represent approximately 3 per cent of my own "first admissions," it appears possible that the incidence of this condition may be the same in private practice as it is in state institutions. It should be noted that these were "routine" private patients and that there was no selective factor determining the type of patients seen.

Diagnosis

Diagnosis based on clinical findings was not as simple as one would expect. The classical symptoms of skin rash and delirium were not present in any of my patients. The history obtained from the patient and the family did not indicate that bromides had been used. The use of bromides was denied even after a positive diagnosis had been made. The families were unable to provide any clues to the source of the bromides in these four cases.

Bromide intoxication is apparently considered to be so unimportant that most textbooks do not mention it. Information about bromide poisoning is more likely to be found in older books, it appears. This suggests that the various symptoms of the condition are not unknown but have been forgotten and overlooked in recent years. In Grinker's and Bucy's textbook, *Neurology,* the following symptoms are listed: lethargy and unsteadiness, dullness and mental confusion, and visual and auditory hallucinations.[2] Dr. Sollman's *Manual of Pharmacology* gives an even more complete list of symptoms. In his description of the condition he includes: psychic deterioration, weak memory, apathy, disturbed speech, ataxia, tremors, somnolence, sexual impotence, paranoid trends, hallucinations, apprehension, and stupor.[3]

Dr. Levin in 1946 noted that bromide intoxication could produce a transitory schizophrenia.[4] Later he offered a complete classification of the effects of bromide poisoning. He divided the symptoms into the following four types:

Simple Intoxication: in this form the patient is dull, sluggish, forgetful and irritable. The pupils are irregular, the gait unsteady and the speech thick.

Delirium: characterized by disorientation, mood disturbances, delusions and hallucinations.

Hallucinosis: marked hallucinations but no disorientation.

Transitory Schizophrenia: in this form paranoid symptoms are seen with delusions, ideas of reference, and hallucinations. It is found in patients with a basic schizoid personality.[1]

Even this very excellent and apparently complete classification did not fit two of my patients. These two had vague symptoms somewhat suggestive of epilepsy or of an epileptic equivalent.

In the diagnosis of bromide intoxication, the electroencephalogram usually offers little specific

Read before the 1957 Annual Meeting of the American Psychiatric Association, Chicago, Ill., May 17, 1957.

The Author

● Dr. Wittenbrook, Cleveland, is a member of the staffs of Ingleside, Marymount, and St. Vincent Charity Hospitals; Instructor in Psychology at Fenn College, and Instructor in Psychiatry at Saint John College, Cleveland.

help other than to differentiate the condition from true epilepsy. One patient admitted to Ingleside Hospital under the care of Dr. Charles Centa had changes in his electroencephalogram commonly associated with drug artifacts. He was a known user of bromides. Hill and Parr in speaking of the possible effects of bromide on the brain wave pattern point out that a higher level of bromides tends to produce diffuse slow activity, but that patients differ so vastly that some with very high blood bromide levels may show no gross abnormalities.[5]

The only certain method of diagnosis is the blood bromide determination. At best this should be done on every patient. I will have to admit that in my practice this was done only on patients having symptoms which in some way seemed atypical of any usual organic or functional mental illness.

Treatment

The generally accepted treatment is to give sodium chloride so that the chloride ion may replace the bromide ion. In my series one gram of sodium chloride was given orally three times a day. Some of the patients were not cooperative in taking medication, so they were given 1000 cc. of glucose in normal saline daily. Vitamin B complex was administered routinely and tranquilizers as needed. Following the suggestion of Sidney J. Tillam subcoma insulin was also given to aid in the elimination of bromides by increasing diaphoresis.[6] This appeared to make the patient generally more cooperative and less agitated.

Case Reports

Case 1. A 52 year old white female, was admitted to Marymount Hospital on November 1, 1955, and was discharged January 22, 1956. On admission she presented a fairly typical Korsakoff's syndrome with loss of memory and confabulation. In about a week after admission she became quite paranoid with delusions and hallucinations. There was a long history of alcoholism. She had always been a little suspicious of people. The paranoid delusions of being poisoned made it difficult to gain her cooperation in eating and taking medication.

The initial blood bromide on November 2, 1955, was 950. Later blood bromide levels were as follows: on November 11, 558; on November 1, 319; on December 1, 153; on December 5, 97; on December 14, 72; on December 23, 28; on December 28, 12; and on January 5, 8.

This same patient was next admitted to Ingleside Hospital on June 28, 1956, where she remained until August 25, 1956. She had been paranoid even before she was admitted to the hospital. In the hospital she was actively hallucinated, hearing voices talking to her under the bed and just outside her window. She thought she was being poisoned by the medication she was given. The blood bromide levels were as follows: on June 29, 1050; on July 9, 1010; on July 25, 202; on August 8, 63; and on August 20, 18.6.

She was readmitted to Ingleside Hospital on October 16, 1956, and was discharged on December 1, 1956. Her mental picture was much the same as it had been at the time of her first admission to Ingleside Hospital. Her blood bromide levels during this admission were: on October 17, 696; on October 29, 186; on November 7, 102 and on November 16, 17.

Comment

This patient (Case 1) is easily classified in the category of transitory schizophrenia. She had delusions, ideas of reference, and hallucinations with a basic schizoid personality.

Case 2. The patient, a 52 year old white male was admitted to Ingleside Hospital on August 13, 1956, and was discharged on September 15, 1956. He had a long history of alcoholism and addiction to barbiturates. He was sent to the hospital because he had become dull, sluggish and irritable at home. He complained of attacks of severe headache or severe facial pain. The history of his complaints was inconsistent and somewhat misleading. He claimed that the illness had been diagnosed as trigeminal neuralgia and also as histamine cephalgia. Due to his irritability and/or pain he had difficulty in sleeping. Some relief of insomnia was obtained through the use of Thorazine® which was given in gradually increasing amounts until he was receiving 100 mg. four times a day.

He did not appear to be either a typical alcoholic or barbiturate addict. Typical withdrawal symptoms of either addiction did not appear. A blood bromide determination was done on August 17 which was 413. On the routine described previously the blood levels fell rapidly. On August 31, the blood bromide was 94 and on September 12 it was 12.

Comment

The symptoms presented by this patient can be classified as "simple intoxication." It is interesting that the physical complaints of headache and facial pain disappeared as the blood bromide level reached normal. I had expected to follow this patient and he agreed to see me regularly at my office. He broke his appointments with me, however. About three months later I received a call from the outpatient clinic of a hospital in Cleveland. This patient had been there several times late at night for medication to relieve severe pains in his head. Several times they had given him narcotics to relieve the pain and had suggested that he return to his "regular" doctor for care.

Case 3. A 53 year old lake boat engineer, was admitted to Ingleside Hospital on July 10, 1956, and was discharged August 25, 1956. The complaint on admission was that the patient had been acting peculiarly and had fainting attacks. There was a delusional trend but this did not appear significant.

Some time before he returned to Cleveland, the home of his brother, he had been found comatose on the street in Chicago. He was admitted to Wesley Memorial Hospital on January 29, 1956, and discharged on February 6, 1956. On admission he vomitted and was unable to respond. He improved while in the hospital and appeared normal at the time of discharge except for a bilateral anosmia. He had a contusion of the left occipital-parietal area. X-rays of the head revealed a linear fracture of the right side of the calvarium. The electroencephalographic findings consisted of mild generalized

changes with a poorly defined region of slow wave activity on the right fronto-parietal area.

At Ingleside Hospital he was found to have a blood bromide level of 456 on July 12. On July 23, the bromide level was 213; on August 8, 73 and on August 20, 13.9.

With blood bromide levels near normal or at normal he no longer had attacks of syncope and seemed normal mentally. He was alert and cheerful. He returned to his home in Florida. A few months later he came back to visit his brother in Cleveland and an appointment was made for him to see me as he was again not "normal" according to his family. He refused to see me claiming that he was afraid that I would put him back in the hospital. In April 1957 he was examined at the Cleveland Clinic and found to have a blood bromide of 107.

Comment

This patient's history was vague and his symptoms somewhat misleading. Both seemed most suggestive of epilepsy. It seems best to call this type of bromide intoxication "pseudo-epilepsy."

Case 4. The patient was a white laborer of 52 years who had a long and interesting history. The details of the history were contradictory. We knew only that he had been a user of narcotics and other drugs. He had once been at the government hospital in Lexington. The past history was more confusing than helpful.

He was first admitted to Marymount Hospital on November 1, 1951, where he remained until November 14, 1951. He complained of weakness and pains in his chest. The working diagnosis was coronary infarction but this could not be confirmed.

He was readmitted to Marymount Hospital on November 30, 1955, and remained until December 8, 1955. He again had peculiar complaints and pain in his upper abdomen or chest. Acute cholecystitis and coronary artery disease were suspected but could not be definitely diagnosed. A psychiatric consultation was requested because of his peculiar actions and the relatives' suspicion that he was still taking drugs. He had many somatic complaints which he appeared to enjoy.

During the next month he came in three times for psychotherapy. He appeared resistive to treatment. In the meantime the family called frequently to report that he was having "spells."

In the middle of January 1956 he was admitted to Polyclinic Hospital with an attack which was again thought to be coronary infarction. He complained of feeling faint and of having pain in his chest. He would not cooperate with the treatment and diagnostic studies. The physician taking care of him suspected that someone might be bringing drugs to him in the hospital. His attitude seemed to be more pleasant after visiting hours.

He was transferred to Ingleside Hospital on January 19, 1956, and remained there until February 1, 1956. He continued to complain of pain in his chest and of weakness. The cardiologist who was asked to see him in consultation was of the opinion that we could not rule out coronary infarction and he recommended bed rest. He was uncooperative in this and so was sent home. We could see no psychiatric reason for having him remain in the hospital.

After his release from Ingleside Hospital, his family continued to complain that he was having "spells." During these "spells" he felt weak and faint, or he might have what they called "temper tantrums."

The patient was next admitted to the psychiatric division of Saint Vincent's Charity Hospital on February 9, 1956, and was discharged on March 13, 1956. He continued to have strange attacks which we suspected were cardiac in origin. Cardiac studies were negative. A large number of laboratory tests were done. These were normal except for the blood bromide which was 143 mg. on February 10th. On February 20, the blood bromide was 57; on February 27, 100; on February 29, 66; on March 5, 33; and on March 12, 22.

Comment

This last patient proved to be the most interesting and yet most puzzling of all these patients. Since the "attacks" stopped when the blood bromide level approached normal, I feel justified in labeling this another example of "pseudo-epilepsy." Follow-up studies would help to determine if this was actually true. The patient, however, has disappeared and none of the several doctors who have known him for years have seen him since.

Summary

Bromide delirium has been completely ignored in textbooks and medical literature or it has been dealt with as an unimportant and insignificant problem. It must be stressed that it can produce definite psychotic symptoms and that the clinical picture may be such that it may lead to an improper diagnosis. Incorrect diagnosis means incorrect treatment. With careful and adequate treatment six or eight weeks are required for recovery.

Bromide intoxication occurring in at least 3 per cent of patients makes it a significant disease. It is probable that the more frequently it is suspected the more frequently it will be detected.

The ease with which bromide intoxication can occur must not be overlooked. As I was preparing this paper in its final form two additional patients came to my attention both illustrating this point. One patient now hospitalized because of bromide delirium, was under my care for psychotherapy during the time he was taking Bromo-Seltzer at the suggestion of a friend. This was done without my knowledge. He was involved in three automobile accidents for which he was responsible. It is now obvious that these were due to bromide delirium.

The other patient, not my own, developed bromide delirium while in the hospital. He had been given bromides for sedation.

It may make the clinical diagnosis easier if we have in mind the five types of symptoms that may be produced by bromide intoxication. The only certain and definite means of detecting this condition is the routine use of the blood bromide test for all hospitalized cases and probably for a large portion of office patients.

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Symptomless Tuberculoma and Hydronephrosis (A Case Report)

REYNOLD E. KLAGES, JR., M. D.

FROM the time that one begins the study of medicine as a medical student, through his student days on into his internship and residency and thence into the private practice of medicine, he hears the oft repeated statements that there is no substitute for a thorough diagnostic study which includes a complete history and physical examination and subsequent follow-up until the diagnosis is established. Every one of us knows that these statements are true and that if followed, bear fruit. However, it seems that their proven value is not often enough brought out in the medical literature today, and that without the oft repeated evidence being presented, we as physicians are liable to forget or become lax in our methods and not "follow through," so to speak.

The following case, I believe, is an excellent example of the value of not only a complete history and physical examination and subsequent follow-up studies, but also of the value of the ever increasing attempt to survey our large population in order to ferret out disease and treat it accordingly. This case exemplifies the value of these three methods of medical approach, namely the survey method, the thorough and complete history and physical examination, and the value of complete follow-up studies.

Case Report

The patient is a 42 year old white male farmer who was sent to this office as a result of having been told that he had certain findings in his survey chest film, taken at the Benjamin Franklin Clinic, which called for further follow-up by his private physician. Due to the fact that this patient did have a 3 cm. lesion in the left lower lung field, which we can call a coin lesion, and which we have subsequently satisfied ourselves is a tuberculoma, it was felt that a complete history and physical examination, plus the appropriate laboratory work would be in order. The patient stated that he had absolutely no complaints, was feeling fine, working every day, but felt that since he had not had a complete examination for "Heaven knows how long," that it was probably a good idea.

As previously stated, the patient had no complaints. He felt quite well, was able to do his work daily and could tell me nothing which he felt would indicate any detrimental condition to his health. His past history was noncontributory except for the fact that he was told, while in the Army in 1945, that he did have a lesion in his chest. This we followed through and were able to make the determination that his coin lesion was radiologically, at least, a tuberculoma. This lesion has become smaller since the original films in 1945.

Family history revealed the fact that he had a brother who died of cancer of the large bowel, and a father who had a coronary occlusion and subsequently died.

His system review revealed only the fact that he had a nonproductive cough and smoked approximately one and one-half packs of cigarettes per day and drank socially. The only other statement he made was the fact that he had noted that his abdomen, the girth of same, was slightly greater than it had been previously, and that he had to let his belt out a notch or two during the past two or three months. He felt, however, that he had gained no weight and could not quite understand what caused him to have this increase in his abdominal size.

Physical Examination

Physical examination revealed a well developed, well nourished white male in no acute distress. Temperature 98.6, pulse 68 per minute, respirations 18, weight 157 pounds. Blood pressure 120/80. The remainder of the physical examination was noncontributory in all respects except for examination of the abdomen.

On examining the abdomen, there was noted what appeared to be a mass which encompassed

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the left periumbilical area and extended upward to the left upper quadrant. The area was approximately 15 by 20 cm., perhaps larger. There was a definite doughy feeling to this area and a definite resistance in relationship to the other quadrants of the abdomen. There was no tenderness noted. On observation of the patient in the prone position, one could see a definite elevation of the left portion of the abdomen in relationship to the right. No fluid wave was elicited and it was dull to percussion. The mass was not movable and was much more difficult to palpate with the patient in the upright position—in all probability due to the muscularity of the abdominal wall.

Laboratory Data

The laboratory reports follow: Electrocardiogram interpreted as being within normal limits. Urinalysis revealed a specific gravity of 1.017, albumin one plus, white blood cells—a few. Hemoglobin 14.75 grams; red blood cell count 5,050,000; white blood cell count 6,700 with 35 small lymphocytes, 8 large mononuclears, 56 neutrophiles and 1 eosinophile. Sedimentation rate 12 mm. per hour. VDRL and Kahn: nonreactive. Fasting blood sugar 103 mg. per 100 ml. Blood urea nitrogen, 22.5 mg. per 100 ml.

X-ray studies were carried out and the coin lesion, as stated in the foregoing was noted but no other abnormal findings in the chest x-ray. The patient also underwent an A-P film of the abdomen, a urogram and a barium enema, as well as an upper gastrointestinal study.

Differential Diagnosis

The conclusion was as follows, and I quote the radiological interpretation: "Differential diagnosis of the mass in the left abdomen: (1) Lymphosarcoma or lymphoma, granulomatous type infiltration; (2) Secondary involvement from the lower portion of the descending colon is not definitely excluded from this study and is certainly an outside questionable possibility of a cirrhosal lesion associated with the lower portion of the descending colon in its posterior mid aspect; (3) Secondary hydronephrosis, left kidney apparently due to pressure from the mass in the left abdomen against the ureter."

The radiologist recommended definite laparotomy in view of the present radiological findings.

The patient was amazed, feeling as well as he did and with no evidence, as far as he could determine, of any ill health, that such a condition could possibly exist. We discussed the situation, and the only reasonable thought was that surgery should be done in order to make a definitive diagnosis and then be able to offer further therapy for whatever the etiological agent might be. The patient was, therefore, hospitalized and a general surgeon consulted. He asked for further urological consultation which was provided, and again it was noted that the left kidney was not functioning and the ureter blocked. Therefore, the patient being in good condition, exploratory laparotomy was carried out.

Operation

The surgical report follows: "A huge lobulated mass extending from the diaphragm all the way into the pelvis and across the midline, the size of a large watermelon was indentified. The base of one of these cysts at the inferior angle of this mass was incised and a large amount of old tarry, endometriosis-like looking material was aspirated. Upon aspirating this, the entire mass collapsed into a collapsed-like balloon. The pedicle vessels were identified and ligated, the adrenals mobilized, freed away from the mass, and the vessels around this were ligated with fine catgut. The pedicle of the kidney was triply ligated, the ureter was immobilized and ligated and a piece removed."

The pathological report was that this was a massive hydronephrosis with extensive degenerative hemorrhage, the result of a congenital defect in the left kidney, at the uretero-pelvic junction.

The patient did quite well following the operation, the only complication being an atelectasis of his right middle and lower lobe, which, with some tracheal suctioning and conservative therapy, did very nicely, and he was discharged from the hospital with no complications. I subsequently have seen this individual as did the surgeon, and he is showing no postoperative complication, is back to work and feeling excellent.

Summary

In summary, therefore, we have an individual, who, through a routine chest survey, was brought to a private physician, who in turn through the avenues of a complete history and physical examination, was able to detect an abnormality in this patient, which, up until that particular time was causing no symptoms. By following this situation to its end point, the diagnosis was definitely made, the situation remedied and the patient was completely cured in this particular case, of his disability. A most gratifying and rewarding experience, I am sure, for all concerned.

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Pancreatin and Some of Its Newer Uses

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THE basic digestive fluid as represented in pancreatin should be of interest to us at all times. These pancreatic ferments contained are capable of digesting every known form of food. Insufficiency or total absence actually causes disease.

Pancreatin is a substance containing enzymes, principally pancreatic amylase, trypsin and pancreatic lipase, obtained usually from the fresh pancreas of the hog.

It is worthy of note here that pancreatin and insulin cannot be obtained from the same gland. This glandular substance is a cream colored amorphous powder, having a faint, characteristic, but not offensive meat odor. Pancreatin is slowly and incompletely soluble in water. It is insoluble in alcohol. Freshness of this product is most desirable.

The association of the pancreas with disease gained importance during the latter part of the preceding century. The more intensive study of this gland has been retarded because of the inaccessibility of the organ, the complexity of its functions, our inability to render the gland opaque for roentgenography and probably above all the hesitancy of the surgeon to explore owing to the very tryptic reaction encountered.

The discovery of insulin, the principal internal secretion of the pancreas, by Banting and Best, announced in November 1921, created new interest in the gland. Intensive studies of the organ have been carried on by L. R. Dragstedt, R. Elman, H. Lagerlof and others.

My own lengthy clinical observations made possible a report[1] on "The Pancreas and Its Relation to Psoriasis, Eczema and Certain Other Diseases of the Skin."

Medication in the Most Common Skin Diseases

Eczema "endogenous," which makes up 30 to 35 per cent[2] of skin diseases for which patients seek medical aid, appeared definitely to be due to some error in diet. Repeated instances indicated disturbance of carbohydrate metabolism. Eczema endogenous may well conform to Urbach's[4] concept of dermatitis "Glycohistechia" which term he uses in dealing with "Carbohydrate Metabolism of the Skin." The observations led to the administration of pancreatin because of its amylolytic properties. At the same time all sources of starches and sugar were withheld. This glandular therapy making up for insufficiency of amylopsin proved satisfactory in the first trial. Since this observation 450 adult eczema patients have been cured or their skin disease satisfactorily controlled, in connection with roentgen therapy. For well defined cases of eczema, roentgen treatment is an essential adjunct to restoring normal skin.

Infants are never given x-ray exposures. Infants displaying a mass of eczema from scalp to feet have made remarkable recovery by simply placing pancreatin in their 24 hour mix of food.

Dosage of pancreatin in all its newer uses does not vary a great deal. Twenty-five to fifty grains are commonly prescribed. Observations have shown no ill effects from extra large doses. Administration of 300 to 400 grains per day shows no particular benefit.

Since the pancreatic juice supplying the enzymes trypsin, amylopsin and lipase is normally delivered to the duodenum in variable quantities, the presence of additional pancreatin does not disturb digestion and good health. On the other hand, where there is known disease due to pancreatic insufficiency, a small dose taken regularly before meals has, in numerous instances, prevented disease.

Eczema patients are given *fresh* pancreatin (25 to 50 grs. in double 00 capsules) and x-ray treatments simultaneously until the skin is well cleared of the disease. Diet therapy is adhered to strictly. Patient and physician will learn to regulate dosage of pancreatin to make up insufficiency of the pancreas. Pancreatin alone in mild eczema cases has been known to prove satisfactory providing a strict diet is followed.

When dealing with most stubborn and persistent cases of eczema and seeming failure of treatment is at hand, it must be remembered that pancreatin is most active and efficient in the presence of bile. Under these circumstances the liver must be stimulated by such drugs as cascara, ox gall, etc.

Pruritus, local or general, probably is the most common and distressing complaint in dermatology.

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Some observations have been made in pancreatin therapy which places this substance at the top as a relief of pruritus originating within the body. It is not uncommon to encounter an aged patient complaining of generalized itching, even needle-like stinging sensations. Pancreatin taken freely will compensate for the diminished activity of this glandular tissue common in the aged. Patients with pruritus, ani, and vulvae after eliminating any local cause of irritation have obtained complete relief after a few x-ray applications, taking pancreatin and correcting the diet.

Roentgen Nausea

Radiation sickness is readily prevented by pancreatin. Cellular disintegration following radiation causes protein intoxication. Having in mind this disorganized protein material, thrown into circulation, it seemed plausible that digestive enzymes would be the proper medication. Prevention of this sickness followed the first dose. This trypsin action of pancreatin powder has been completely effectual in 350 cases since first use in 1942. While this glandular therapy is not thoroughly understood, the benefits are believed to take place in the liver. Administration of medication is simple. Immediately after radiation treatment is given, 50 grains—two 00 gelatin capsules—are given followed by glass of water. This early and immediate ingestion adds to the effectiveness. At home, have patient repeat capsules before each meal during series of treatments.

Food allergy will be dealt with here only in a small way as compared to the importance of allergy in its entirety. It is difficult at times indeed to determine what is truly a food allergy. When food is ingested, what happens if digestive juices and enzymes are absent wholly or in part? Under these conditions, food becomes a foreign substance and irritant to the intestinal mucosa resulting in a diversity of reactions. It is a daily observation to see allergy to some of the most common foods disappear promptly after giving pancreatin. Patients thought to be allergic have been denied food almost to a starvation diet. In my own experience, when pancreatin was prescribed 90 per cent of these cases recovered their normal health and sense of well-being.

Insufficiency of the pancreas as related to food allergy was noted by Nathan:[3] "A child hypersentitive to eggs presented a clinical picture of erythema and diarrhea. The stool was found to have a high content of neutral fat and poorly digested muscle fiber. During the period of treatment with pancreatin, eggs were tolerated, but the allergic symptoms recurred when the pancreatin was stopped. Renewed administration of pancreatin extract again resulted in freedom from symptoms."

Cosmetics have a share among the newer uses of pancreatin. Roentgen therapy of the face at times leaves much to be desired in the way of normal and pleasing skin. Pancreatin powder freshly mixed with water to the thinnest paste consistency and applied over entire face with a cotton or gauze applicator, for a few minutes, always improves the skin and frequently delights these unfortunate people.

This therapy is indicated in acne, seborrhea, presence of blackheads and a number of conditions where the skin is rough or oily. The mild epilating action results in an apparent bleaching effect. The smoothness of surface and fresh pink color results in a more youthful appearing skin. The activity of this therapy is due to trypsin which digests or softens the facial debris. The enzyme lipase dissolves the fats or seborrheic material. Caution is urged here against carrying this tryptic or dissolving action of the skin too far.

Pancreatin therapy as given in the foregoing, represents some of its most important uses. One's interests in these enzymes will reveal additional therapeutic values.

Lipase insufficiency—Xanthomas, disturbances of lipid metabolism—bears same relationship as amylopsin does to eczema endogenous.

Trypsin insufficiency revealed in skin lesions will undoubtedly show excessive protein tissue in local areas.

The Skin as a Reflector of Pelvic Disease

Under the title of this paper, infection of the pancreas may seem to be wholly unrelated. However observations point to further relationship between the pancreas and skin reactions.

A very critical consideration of the pelvic lymphatic system as a channel conducive to skin infection is so remote physically, that such a process is seldom suspected and almost impossible to prove. The pre-aortic lymph glands anastomose with each other. They receive lymph from the stomach, intestines, liver, pancreas, and spleen. In due turn, the pre-aortic anastomosis receives large drainage from the entire pelvis. Infections from the rectal tissues and all genital organs are in direct line of drainage into the pre-aortic anastomosis —and thence into any of these upper abdominal organs. Herein lies a field of much interest.

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Jejunal Diverticulum with Perforation

Report of a Case and Brief Review of the Literature

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THE jejunal diverticulum is a rare condition, but of serious enough import to be worth review of the subject and a report of unusual complications. In 1900 Fisher[4] in a report stated that the first cases of jejunal diverticula were described by Sommering in 1794 and in 1804 by Voigtel. Six years later Gordinier and Sampson[6] described a living patient with jejunal diverticulosis.

Etiologically the diverticulum may be congenital or acquired. Usually the congenital is solitary and located, as Meckel diverticulum, on the antimesenteric border of the intestine. The acquired, however, is usually multiple and located on the mesenteric border.

The congenital diverticulum contains all of the layers of the bowel, while the acquired usually exhibits an absence of one of the muscular coats, the longitudinal layer. The acquired is most often seen after the age of 40 years and is thought to be mucosal herniations at the site of vessel perforations. It is believed to be secondary to increased pressure resulting from abnormal peristaltic waves.

Roentgenologically in 1934 Rankin and Martin[10] reported three cases in 956 examinations or an incidence of 0.31 per cent; two years later Edwards[3] reported four cases found in 4,631 examinations or an incidence of 0.08 per cent.

By necropsy in 1936, Rosedale and Lawrence[11] reported four cases of jejunal diverticula in 300 consecutive autopsies or an incidence of 1.3 per cent. Fifteen years later, Orr and Russell[8] had an incidence of nine cases of 2,161 autopsies or 0.4 per cent.

The signs and symptoms of jejunal diverticula have been most adequately reviewed and discussed by Fraser[5] in 1933; Benson[1] et al. in 1943, and once again by Mahorner and Kisner[7] in 1947. For the most part this can be a relatively asymptomatic condition unless complications supervene to call it to the physician's attention. In short, the symptomatology is that of its complications.

The major complications were well classified by Milnes Walker[15] in 1945 as follows:

1. Acute diverticulitis causing:
   a. Generalized peritonitis
   b. Local abscess formation
   c. Adhesions
   d. Acute intestinal obstruction

   These may or may not be associated with perforation.
2. Concretion formation with or without obstruction.
3. Hemorrhage.
4. Traumatic rupture.
5. Volvulus.
6. Jaundice (Nicholson) 1935.

The incidence of complications, however, is rather rare with inflammation and concretion as the more common, and, probably, traumatic perforation as the most uncommon. This of course is not too surprising for a number of reasons:

1. The wide neck of the diverticulum.
2. The rather fluid, sterile intestinal content at this level.
3. The low intraluminal pressure.

Thorek and Manzanilla[14] in reviewing the literature in 1954 found 15 cases of perforation of jejunal diverticula of which two were traumatic and the remainder inflammatory. There were five solitary and 10 multiple jejunal diverticula. They added their own case of a solitary jejunal diverticulum which had perforated. Fourteen cases were treated surgically, one case was diagnosed at necropsy, and the treatment of the remaining patient was not reported. The overall mortality in the surgically treated patients was 40 per cent. And thus to this we would like to add an additional case of traumatic perforation of a solitary jejunal diverticulum successfully treated surgically.

Case Report

The patient, a 69 year old white farmer, was admitted to the hospital on August 18, 1953, at 4:15 p.m. complaining of stabbing pain about

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the umbilicus. The pain began the day previous to admission about the umbilicus. He had spent a restless night; the pain had grown more generalized and severe. He called his physician. During this time he became more nauseated but did not vomit. One week previously the patient had a mild gastrointestinal upset consisting mostly of abdominal discomfort and diarrhea. On August 17, 1953, he had one loose yellow stool, which was repeated on the day of admission.

Past History: His general health was good. There was a history of several minor falls and accidents.

Medical and Surgical Diseases: No significant history. General: In the past few months the patient had noted that he fatigued somewhat more easily, and became dyspneic on occasion.

System Review: In respect to the head, neck, heart and lungs: this was normal, except for the occasional dyspnea on exertion.

Gastrointestinal: There was a good appetite with no food intolerance. There had been several bouts of diarrhea recently but no melena, constipation, acholic stools, or weight loss.

Bones and Joints: There had been occasional pain in the right elbow. There was limited abduction of the right shoulder.

Family History: Both parents were dead of unknown causes. One younger sister had died of tuberculosis, and one sister had diabetes mellitus. One brother and one sister were living and well.

Physical Examination: Blood pressure 130/85, temperature 98.6°, pulse 100 per minute, respirations 32 per minute. *General:* The patient appeared to be restless and acutely ill. The eyes, nose and throat were normal. The neck was supple with no nodes palpable. *Thorax:* Symmetrical bilateral and normal. There were normal male breasts. The heart and lungs were normal. *Abdomen:* The abdomen was moderately protuberant and moderately rigid, especially in the right lower quadrant. This area was the point of maximum tenderness and there was marked rebound tenderness here. There was minimal tenderness in the other areas.

The bowel sounds were absent. There was no contralateral tenderness or obturator sign. There was, however, a positive psoas sign. There was no dullness in the flanks or palpable masses or hernia. *Back:* Normal. *Extremities:* There was marked limited abduction of the right shoulder and some limitation of the right elbow. *Neuromuscular:* The reflexes were physiological and present. *Rectal examination:* There was moderate hypertrophy of the prostate but no nodules or tenderness.

Laboratory Studies: Blood: hemoglobin 16.5 Gm.; red blood cell count 5.19 million; white blood cell count 18,000, 18 segmented forms, 10 band cells, 1 eosinophil, 15 lymphocytes, and 1 monocyte. Urinalysis: the color was clear amber; there was an absence of sugar, albumin and acetone. There were no microscopic findings. A diagnosis of acute appendicitis was made. The patient was prepared for surgery and taken to the operating room.

Operation

The abdomen was opened through a right paramedian incision, the cecum was visualized and brought into the wound. About the cecum there was a moderate amount of watery, opalescent material, not appearing to be purulent. There was a moderate periappendicitis but it was not felt that the appendix was the primary site of disease. The incision was extended and thorough laparotomy carried out.

The colon was palpated and visualized throughout its length. In the sigmoid colon there were a few small diverticula with a moderate amount of reaction about them. The gallbladder was visualized and found to empty easily and be free of stones. The wall was thin. The pylorus and stomach were carefully examined and found to be normal. Complete examination of the small bowel revealed a jejunal diverticulum approximately 6.0 cm. from the ligament of Treitz. This was located on the mesenteric border. It was approximately 4.0 cm. in length and was perforated at its apex by a piece of bone. The bone protruded into the mesentery and into the peritoneal cavity. A moderate amount of intestinal contents was seen exuding from the area of perforation into the peritoneal cavity. The viscera were packed away and the mensentery freed about the diverticulum.

The dissection was carried about the neck of the diverticulum. Rubber shod clamps were placed on the jejunum. The diverticulum, with a small amount of jejunal mucosa, was excised. The defect was closed transversely in two layers with chromic gastrointestinal suture. Several cotton buttress sutures were placed on top of these.

The bone removed from the specimen measured 3 by 0.5 by 0.5 centimeters. It was roughly shaped like a golf tee.

The rent in the mesentery was repaired and the appendix was removed. The incision was closed with a continuous No. 0 chromic suture in the peritoneum and interrupted No. 00 cotton sutures were placed in the fascia. There were several No. 0 black silk stay sutures used. The skin was approximated with skin clips. A rubber

drain was brought out through a stab wound in the left flank.

The Pathological Report

Gross Examination: The specimen consists of an appendix measuring 6 by 7 cm. The external surface is smooth and glistening, vessels moderately congested. The second specimen is a portion of small intestine, the serosal surface of which is thickened and has lost its normal translucency. There is a perforation noted at the apex.

Microscopic Examination: Section of the appendix shows the lumen to be obliterated and the wall to be infiltrated with a few lymphocytes. Specimen No. 2: Section of the small intestine shows a small perforation. Submucosa, muscular coat and subserosa are edematous and diffusely infiltrated with a mixture of neutrophilic leukocytes, lymphocytes and plasma cells. The serosal surface is covered by a thick layer of fibrin containing a large number of neutrophilic leukocytes. One point near the center of the specimen, the muscular coat is absent, the wall of the bowel is absent.

The Pathological Diagnosis: Fibrosis obliterans of appendix. Diverticulum of the small intestine with acute diverticulitis and perforation.

Postoperative Course

The patient was returned to his room in good condition. He was put on nasal suction, given parenteral fluids and a Foley catheter was placed in the urinary bladder. After surgery he remained afebrile with the temperature reaching 99.4° on one occasion. His pulse, blood pressure and respirations were stable at all times. The urinary output was adequate at all times.

On August 21, 1953, the patient had gas pains and passed flatus. He was given a water and glycerin enema with good results.

On August 22, 1953 the nasal tube was removed. His abdomen was soft and normal bowel sounds were present.

August 27, 1953: His wound was healed primarily. His skin clips and drains were removed. He was enjoying a regular diet, having normal bowel movement, good urinary output, and was free from symptoms or findings. He was discharged from the hospital.

Follow-up in office: The patient was seen on September 1, 1953. His wound was well healed, and there were no findings or complaints. All functions were normal. He was last seen in January, 1954 at which time he was free from findings or symptoms. He was discharged to his family physician. At this time the patient was questioned concerning the time or mode of ingesting the bone. He did not recall but did state that he had "gotten new dental plates" just previous to his illness and had "some difficulty with a steak bone" at this time.

Discussion

We feel that this patient well represents the problems of perforation of a jejunal diverticulum. It also points up the necessity of painstaking, thorough laparotomy.

This case, as usual, is seen in a patient beyond 40 years of age; however, this condition has been reported by Benson, Dixon and Waugh[1] to have been found in a 13 year old female who had had symptoms for nine years.

In this instance, it was possible to resect the diverticulum without encroachment upon the bowel proper. This is not always the case. Quite often, resection of the involved segment of bowel and anastamosis is necessary. It has been possible to invaginate the diverticulum in several cases; while in a few, suture of the perforation and an omental patch was the method of choice. And finally, in a few severely ill patients the operator bypassed the lesion and drained the abdomen.

This patient presented himself with the predominant complaint of right lower quadrant pain; however, most of the patients present left lower quadrant pain and tenderness, or epigastric findings, otherwise we believe this to be a rather typical picture of a somewhat rare entity.

We also offer this as an additional differential diagnosis to the operator, who in operating for acute appendicitis is confounded by a relatively innocuous vermiform appendix.

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Fever and Anemia Due To Carcinoma of the Urinary Bladder with Metastases — (Case Report)

RICHARD W. WATTS, M. D.

THIS case report was prompted by the initial symptoms of low grade fever and refractory anemia in a case of metastatic tumor arising from the urinary bladder.

Case Report

The patient was a 67 year old white male who began having dysuria and hematuria two years before death. Transurethral resection of the prostate was done and carcinoma of the prostate was diagnosed for which bilateral orchidectomy was performed and stilbesterol prescribed.

Because of persistent symptoms another cystoscopy was performed 16 months before death. At that time physical examination was unremarkable. Normal laboratory findings included red blood cell count, hemoglobin, white blood cell count, serologic tests, blood urea nitrogen, acid phosphatase, and chest x-ray. Urinalysis showed 25 white blood cells and 20 red blood cells per high power field. Transurethral resection and cystotomy with insertion of radon seeds into an infiltrative poorly differentiated transitional cell carcinoma of the bladder was performed. In retrospect it was thought that the original lesion actually arose from the bladder and invaded the prostate rather than being primary in the prostate.

Studies one year and again nine months before death showed normal physical and laboratory findings. Cystoscopy and biopsy each time revealed only chronic inflammation. Following the last cystoscopy the patient began experiencing a low grade fever often as high as 101 degrees. Physical examination seven months before death was negative.

The following laboratory findings were then recorded: red blood cell count 3.5 million, white blood cell count 7,600, hemoglobin 11 grams, 9 and 9.5 grams, hematocrit 32, mean corpuscular volume 110, mean corpuscular hemoglobin 27, mean corpuscular hemoglobin concentration 29, negative serology, normal urinalysis, blood urea nitrogen 16 mg., phosphorus 3.5 mg., alkaline phosphatase 5.2 units, icterus index 3.4 units, total serum proteins 5.4 grams with albumin 3.0 grams and globulin 2.4 grams; febrile agglutinins were negative. Numerous blood, urine, and stool cultures were negative. Chest, colon, and pelvic x-rays were negative. Bone marrow aspiration revealed normal cells. The fever subsided while he was in the hospital.

Despite ferrous sulfate therapy his hemoglobin was consistently 10.5 grams and daily temperatures showed spikes as high as 102 degrees. Because of rapidly enlarging suboccipital and right axillary nodes he was hospitalized five months before death. Biopsy of a node showed undifferentiated carcinoma. Complete x-ray survey showed normal findings in the kidneys, sinuses, gallbladder, esophagus, stomach, and duodenum. Rib and vertebrae x-rays were inconclusive. Otorhinolaryngeal examination was normal. Progressive emaciation with enlarging peripheral lymph nodes and signs of lumbar spinal cord compression with leg paralysis and loss of sensation, urinary and fecal incontinence characterized the terminal course.

The autopsy findings (performed by Dr. Oliver Eitzen, pathologist at Lakewood Hospital) were undifferentiated carcinoma of the spleen, right adrenal, prostate, axillary, periaortic, mesenteric, and iliac lymph nodes and second lumbar vertebra with epidural compression of the spinal cord. Also found was a right pleural effusion, chronic pyelonephritis, and chronic cystitis without evidence of tumor in the bladder.

The Author

● **Dr. Watts, Cleveland, is a member of the staffs of Cleveland City, Lutheran, Lakewood, and Fairview Park Hospitals; also Director of the Cardiovascular Laboratory, Fairview Park Hospital.**

Discussion

The presence of low grade fever in metastatic carcinoma has been noted many times. It also may occur with primary tumor before metastases appear. Keefer and Leard[1] refer to this but do not record any examples in which fever was associated with metastatic carcinoma from the bladder. They do mention two cases of prostatic carcinoma with fever. Fever is most common in carcinoma involving the kidney, liver, bones, lungs, and lymph nodes. The occurrence of fever after a tumor operation suggests tumor recurrence. One case of carcinoma of the bladder is found in the report by Rodriguez[2] He also emphasized the early appearance of arthritic symptoms and fever weeks or months before carcinoma was diagnosable.

The mechanism of anemia in carcinoma has been shown often to be due to a hemolytic component as attested by high fecel urobilinogen excretion and red cell survival techniques.[3] Marrow activity was usually normal or increased but failed to compensate for hemolysis.

Metastases from infiltrative tumors of the bladder are not uncommon. Jewett[4] has shown that curability drops from 100 per cent for tumors limited to the mucosa to 26 per cent if perivesicular infiltration has occurred at the time of treatment. Metastases are most commonly to regional lymph nodes, liver, lungs, vertebrae, sacrum, and pelvis. However death from bladder carcinoma is usually due to urinary tract infection, often a complication of obstruction.

Summary

1. A case of carcinoma of the urinary bladder with widespread metastases first manifested by

fever of unknown origin and refractory anemia is reported.

2. The importance of fever and anemia as early signs of metastatic carcinoma is emphasized.

Acknowledgment: The author wishes to thank Dr. William Huffman and Dr. Oliver Eitzen for their assistance in the preparation of this report.

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• ONE OF OUR readers has objected to a statement made in a recent article in *The Journal* on early detection of recurrent cancer. Here are her reasons.—EDITOR.

Early Detection of Recurrent Cancer

I read with much interest the article by Dr. Anton W. Oelgoetz in the March 1958 issue of *The Ohio State Medical Journal* (pp. 335-337), entitled "Carcinoma of the Cervix with Metastasis —A Case Report." I find it quite difficult to accept without comment the last one of his three concluding remarks, which reads: "The Papanicoloau test is unreliable after irradiation."

Surely a considerable number of recurrent carcinomas of the cervix occurs locally. In these cases cytology is certainly of value in detecting an early recurrence.

In 1952, an article was written by Dr. J. B. Graham and Dr. J. V. Meigs* reporting seven cases of cancer of the cervix, (four after irradiation and three following radical surgery) in which the cytologic diagnosis of recurrences antedated a biopsy confirmation by an average of 14½ months. They wrote: "Physical examinations did not show diseases in any of these patients up until the time of the positive biopsy, and in three it was not grossly apparent even then. The smear directed attention to these cases and as many as three negative biopsies were taken before the presence of cancer could be verified histologically." Their conclusion was that ". . . Local recurrence of cancer of the cervix may be recognized cytologically from the vaginal smears long before the tumor is grossly detectable." — Winifred Liu, M. D., Head, Division of Exfoliative Cytology, The Youngstown Hospital Association.

*Reference: Graham, J. B., and Meigs, J. V.: Earlier Detection of Recurrent Cancer of the Uterine Cervix by Vaginal Smear. Am. J. Obst. & Gynec., 64:908, October, 1952.

Selective Readings . . .

Matter, Mind and Man: The Biology of Human Nature, by Edmund W. Sinnott. ($3.50. *Harper and Brothers, New York 16, N. Y.)* This is volume XI in a series on world perspective by the director of the Sheffield Scientific School of Yale, and Dean Emeritus of Yale's graduate school. It is an appeal to those who may not be satisfied with religious orthodoxy but who also reject purely materialistic explanations of man and the universe. The series has been planned as a program to bring to the public short books in a variety of fields by distinguished contemporary thinkers. The purpose is to reveal basic new trends in modern civilization and to interpret the creative forces at work today in religion, politics, arts and the sciences that we might get a deeper understanding of the interrelationship between man and the universe, individuals and society and the values which are shared by all people.

Practice of Medicine, by Jonathan C. Meakins. ($16.00, sixth edition, *C. V. Mosby Co., St. Louis 3, Mo.)* The author emphasizes that it should be appreciated that there are fundamental and even simple concepts with which every student and practitioner of medicine must be armed. There has been an increasing tendency for professors of medicine to be specialists in only some one branch of their profession. It follows, therefore, that their personal teaching tends along these lines. This is not good for the undergraduate, however good it may be for the graduate or the residents. In spite of the fact that the author has expanded the editorial staff to include a group of associates, each within his own particular realm, the text is an integrated one and is, with its 1950 pages, a very excellent reference for every one interested in internal medicine.

New Answers to the Fatigue Problem, by Adelaide K. Bullen. ($4.50. *University of Florida Press, Gainesville, Florida.)* The author was formerly a member of the Fatigue Laboratory at Harvard University. This book presents the results of scientific studies of the United States Army personnel, laboratory experiments on men and women and on-the-job research in office and factory. Text and charts and graphs show differences in body build and behavior and suggests recognizing these differences in yourself and others. These give you, then, a springboard for new answers to the fatigue problem. As fatigue is often a prelude to physical or nervous illness the answers found in this book indicate, among other things, ways to combat absenteeism on the job and represent also a contribution to preventive medicine and to public health in its very broadest sense.

Interstitial Keratitis

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness, which can in many instances be averted by proper, timely care.

Case Report

This 19 year old boy has had severely reduced vision (able to count fingers only with each eye) as long as he can remember. Visual loss followed an acute bilateral ocular inflammation in childhood. Because of the pathognomonic proliferation of blood vessels seen on the deep surface of the cornea with the slit lamp microscope and because of a history of positive reaction to serologic tests for syphilis, his diagnosis is definitely interstitial keratitis. He is now hospitalized for corneal transplant.

Discussion

This case illustrates several ways in which visual loss may be prevented. Interstitial keratitis is almost always a manifestation of congenital syphilis. Detection of syphilis by routine serologic tests during pregnancy with subsequent specific penicillin treatment, has almost eliminated interstitial keratitis. Public health records show a continuing incidence of new cases of syphilis, however, and maternal serology is still a most necessary examination.

Since the advent of steroids it has been possible to minimize corneal scarring from the acute attack of interstitial keratitis. Hourly topical application of cortisone or prednisone relieves redness, photophobia, and corneal infiltration within a few days, but should be continued in reduced frequency for three to four weeks. Systemic steroids are helpful in a very severe attack.

Atropine is one of the most neglected medications in treatment of severe corneal disease. Almost invariably iritis will accompany severe inflammatory corneal pathology such as interstitial keratitis. Dilation of the pupil with 1 per cent atropine three times daily will prevent serious adhesions between the iris and lens.

Antibiotics, topical or systemic, are NOT helpful in treatment of acute interstitial keratitis. Naturally penicillin should be used in treatment of the congenital syphilis, but it will NOT prevent corneal scarring.

The need for accurate differential diagnosis of a red eye is obvious. Misdiagnosis of a case of interstitial keratitis as "conjunctivitis," and failure to use steroids, mydriatics, and antibiotics as outlined, will result in disabling corneal scarring as sustained by the patient reported here.

Finally, corneal transplanation offers great hope for this group of patients. The percentage of successful results is relatively high, and the patients (usually young) are enabled to lead more productive and enjoyable lives.

The Author

● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

Compression Fractures of Dorsal Or Lumbar Vertebrae

One of the most frequent of severe injuries in orchard work is injury of the back, particularly a fracture or a sprain due to a fall from one of the three-legged ladders used for picking tree crops. The ladder itself is usually 12 to 14 feet in height and weighs 40 to 60 pounds.

Usually injuries resulting from a fall in which the patient lands on his buttocks or across his picking pail are compression fractures of the dorsal or lumbar vertebrae. The patient must then be treated in hospital for reduction of the fracture by hyperextension, and application of a body cast. Later a brace such as the Jewett or Taylor brace may be used.

Lashier expressed the opinion that a disability of one year should be accepted as probable in all crushing fractures of the vertebral body. Some patients are inclined to have symptoms for a period of years. McBride said that in cases of cervical fractures the patient may be expected to resume work in 30 to 40 weeks and that for lumbar and dorsal fractures at least 42 weeks should be allowed and the patient should be returned to light work as soon as possible. D. P. LaTourette, M. D., Ceres, Calif.: *California Med.*, 87:142, 1957.

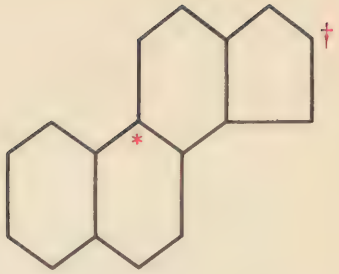


LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle announces a major drug with great new promise

Arist

a new corticosteroid created to minimize
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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension-Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort

in Nephrotic Syndrome

Fourteen patients with the nephrotic syndrome have been treated with ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

Eleven patients with pulmonary emphysema and/or fibrosis were treated with ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

Forty-four children and adults have been given ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle

The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◊ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

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in Disseminated Lupus Erythematosus

◊ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Lederle



TOPIC THIS MONTH:

Maternal Deaths* Involving Amniotic Fluid Embolism

Case No. 165

This patient was a 22 year old, white, gravida III, Para II, 30 weeks' gestation, dead on arrival at the hospital, undelivered.

Her previous obstetrical history revealed a toxemia with her first pregnancy, delivered at term. The second pregnancy was uneventful, delivered spontaneously at term. In the last pregnancy she registered with her physician two days before her death. A complete physical examination revealed normal findings with an intrauterine pregnancy approximately 7½ months' gestation.

On June 20, shortly after the patient arose in the morning (of her death), she suddenly collapsed at home, was rushed to the hospital, and was pronounced dead on arrival. An autopsy was done by the coroner.

Pathological Diagnosis: Pulmonary infarction; amniotic fluid embolus; infarct of the placenta; pregnancy uterine, dead fetus 1430 grams. (Amniotic sac previously ruptured.)

Comment

The Committee studied this case with more than considerable interest, especially since a report of the microscopic examination of the lungs revealed "Some of the arteries of the lung, as well as the capillaries, show presence of . . . a large irregular cell occluding the lumen, which closely resembles a decidual cell of the placenta." There was no history of labor or convulsions (such as were reported in Case No. 132, *Ohio State M. J.*, 53:419, April, 1957). By unanimous vote this case was classified a nonpreventable maternal death.

Case No. 176

This patient was a 30 year old, white, Para V, who died three hours postpartum. Her past history, including pregnancies, was not remarkable. She registered in her fourth month with a last menstrual period September 3, and had eight prenatal visits, with an uneventful course.

On June 13 (at term) her membranes ruptured spontaneously at home and she was promptly admitted to the hospital at 3:45 a. m. After eight hours of light, ineffectual labor x-ray pelvimetry revealed no disproportion, with the presenting head not engaged. Consultation was obtained, recommending cesarean section if a trial of labor was unsuccessful. Ultimately the patient was scheduled for surgery, but she suddenly went into vigorous labor and had a precipitous delivery on the operating table at 5:35 p. m. June 14, of a 6 pound, 7½ ounce living baby. The infant required resuscitation, after which its condition remained satisfactory.

At 6:00 p. m. the patient was returned to her bed; an hour later she was found in a pool of blood and was in shock. Plasma was given, followed by 1,000 cc. of blood under pressure at 8:00 p. m. The patient's condition deteriorated rapidly and she died at 8:25 p. m. Blood drawn for type and cross-match did not clot! Permission for autopsy was obtained.

Cause of Death: Hemorrhage, postpartum; amniotic fluid embolism; pregnancy at term delivered.

Pathological Diagnosis: Amniotic fluid emboli of lungs (fragments resembling keratotic vernix cells); bronchopneumonia; acute inflammation of decidua (uterus).

Comment

The Committee noted that this case was more characteristic of the pattern followed by this lethal syndrome, including the coincidental afibrinogenemia. Data in the case are not available in detail, but when blood was drawn from the patient and it was observed not to coagulate, fibrinogen should have been administered at once, in addition to plasma. Further, after precipitous delivery the fundus and blood pressure should have been watched constantly for at least an hour. By a narrow majority, the Committee voted this a nonpreventable maternal death.

Comment of Consultant

The following comment of a consultant who is a specialist in pathology, was given at the request of the Committee.

Maternal collapse occurring during labor or shortly after delivery with symptoms of chilliness, restlessness, anxiety, dyspnea, cyanosis, shock, and death plus the autopsy demonstration of amniotic fluid elements (squame, mucus, lanugo hair) in blood from the right heart or sections of pulmonary vessels has been ascribed to amniotic fluid infusion. It is a catastrophic, shocking, dumbfounding ac-

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

cident and one in which a set of circumstances for successful therapy can scarcely be imagined. The nature of the tragedy and mechanism of death have yet to be completely elucidated, but anaphylactoid shock, widespread intravascular clotting and plugging of pulmonary vessels by particulate material are mentioned.

Clinically the patient is usually an elderly multipara with a large baby who has a violent labor with strong uterine contractions and possibly premature placental separation although the latter may not be evident. It is reasonable that there must be a communication between the amniotic cavity and uterine sinusoids with sufficiently hard contractions to force amniotic fluid into the maternal circulation. Under these circumstances it is easy to imagine all degrees of amniotic fluid infusion from minimal to lethal doses.

Should the patient survive the initial shock phase, the blood may be observably incoagulable and marked hemorrhagic tendencies may quickly develop. This may possibly be explained on the basis of depletion of the baby's store of fibrinogen by the thromboplastic action of amniotic fluid plus meconium and extracts of decidual tissue which are notably rich in thromboplastin. The fibrin deposits are sometimes intravascular or possibly found in excessive amounts on a prematurely separated placenta. Similar hypofibrinogenemia has been observed when there is prolonged, intrauterine retention of a dead fetus[1] and in the newborn.[2]

The hypofibrinogenemia is suspected by the bleeding tendencies or the incoagulability of blood in a test tube, and may be confirmed by fibrinogen determination. Under these circumstances, the administration of fibrinogen up to complete replacement (6 to 8 grams) is the logical therapy.

Fortunately lethal amniotic fluid infusion is a rare cause of maternal mortality and therapy is difficult. I would quite agree with the Committee classifying **Case No. 165** as nonpreventable, but would probably vote with the minority on **Case No. 176** on the basis that the patient should have been watched more closely for the one hour and twenty-five minutes postpartum and should possibly have had intravenous fibrinogen when the blood was found to be incoagulable. However, I must admit, the outcome might have been the same.

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Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Case No. 55. This is a 49 year old white female who at age 39, ten years ago, had onset of vaginal bleeding. Approximately five years after the onset of this bleeding she consulted a physician. Endometrial carcinoma was found. Therapy was given by radium in tandem. She was to have a follow-up hysterectomy. The patient, however, states that she felt well after this and had no further bleeding and did not submit to the operation. She is admitted to the hospital at this time with a history of prolonged vaginal bleeding. Physical condition to date has prohibited dilatation and curettage.

Impression: Terminal endometrial carcinoma.

Comments: Patient delay five years before treatment instituted, then patient un-co-operative in carrying out the definitive surgery indicated. There is a great need for education and persistent patience in a patient like this.

Case No. 56. This is an 81 year old white female. Normal menopause at age 50. Began bleeding 12 months ago. In the past year she had had several episodes of vaginal bleeding. She has been treated for the past four years by her family physician for hypertension and was told by him six months ago that her bleeding was due to high blood pressure. She was examined by her physician one month ago and immediately referred to a Cancer Clinic for further treatment. She has a biopsy diagnosis of squamous cell carcinoma of the cervix.

Comments: Physician delay, four years. When under treatment the patient's symptoms of vaginal bleeding should have alerted this physician to the potential hazard of malignancy. Hypertension is not a cause of vaginal bleeding.

Case No. 57. This is a 51 year old white female who had a subtotal hysterectomy nine years ago. She began having vaginal bleeding for the first time since the operation two years ago and had another abdominal operation the exact status not known. She did have radium therapy applied centrally subsequent to surgery. Two months ago she began having back pain.

Pelvic examination reveals tumor tissue at vaginal apex. Rectal examination reveals a 5 to 6 cm. mass encroaching on the anterior rectal wall extending to the pelvic wall.

She received external radiation therapy to tolerance.

Comments: Unfortunately we have yet to see the end of the long line of individuals who will appear with carcinoma of the cervical stump.

Impression: Inadequate surgical approach nine years ago.

Bacterial Infections in Situations Of Altered Host Resistance

It is probable that certain bacteria, which commonly live quietly within us will continue to produce active disease in situations of reduced host resistance. Information about the precise biologic and biochemical defects which characterize increased susceptibility to infection may offer a new approach to the human infections which are currently causing therapeutic difficulties.—David E. Rogers, M. D., New York: *Connecticut M. J.,* 22:1-10, January, 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 71 year old white female was admitted to the University Hospital, Columbus, Ohio, because of splenomegaly first noticed three years prior to admission, and abdominal distention first noticed one year prior to admission. Thirty years ago, after a four-year history of bouts of nausea, vomiting and epigastric pain related to the ingestion of egg-containing food she had a cholecystostomy with removal of stones and bile drainage. Approximately one week postoperatively she developed jaundice which lasted for about one week and never recurred. Her preoperative symptoms disappeared completely but for about three months postoperatively she remained quite ill.

The patient then improved and had no specific acute or chronic illness until three years ago, when she gradually developed abdominal discomfort, shortness of breath and swelling of her ankles. Her physician found an enlarged spleen and anemia and put her on iron therapy. This treatment was apparently continued until one year ago, when she was admitted to her local hospital with weakness, rather severe shortness of breath, retention of urine and left flank pain which was thought to be a renal colic. She received 6 units of blood and improved markedly, particularly with regard to her abdominal distention. She was put on a low-sodium, low-calorie diet, lost 47 pounds over the following eight months, and felt better than she had for a long time.

A few months ago her dyspnea gradually returned and slowly progressed, culminating in an acute episode of dyspnea with tachycardia and palpitations three weeks ago. The dyspnea was felt as a sensation of oppression, was relieved by rest and was not accompanied by pain. Following this episode the patient began to notice the return of her abdominal distention, which persisted in spite of transfusion with 5 units of blood. She was then transferred to the Ohio State University Hospital for further evaluation.

Previous illnesses included mumps, measles and chickenpox in childhood. An umbilical hernia developed after the birth of her seventh baby and became progressively larger. She developed cataracts over the past 15 years. She had a lifelong history of frequent mild epistaxis, and many sore throats until quinsy 20 years ago. Her father died at the age of 69 of heart trouble; a son died from rheumatic heart disease.

Presented by

- **Edwin H. Ellison, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Physical Examination

The patient was an elderly, rather poorly nourished white female appearing chronically ill. Her temperature was 98.6°F., pulse 68, respirations 22, blood pressure 186 over 66. The lungs showed bilateral basal dullness with numerous moist crackling rales over both bases. There was marked abdominal enlargement with signs of ascites, and a large mass considered to be spleen occupied the left upper abdominal quadrant and extended to the iliac crest. There was also a huge ventral hernia containing bowel. The liver was not palpable. The heart was apparently not enlarged and showed a grade 2 apical systolic murmur. There was 3 plus pitting edema of both legs up to the groins and 1 to 2 plus sacral edema. The lymph nodes were not remarkable.

Laboratory Tests

Her hemoglobin was 12.5 Gm., reticulocytes 1.2 per cent, the total white count 2,150 with 80 per cent polymorphonuclear leukocytes, 10 per cent small lymphocytes and 5 per cent monocytes. Her platelets numbered 253,440. Bone marrow aspiration showed a very cellular marrow with normal megakaryocytes and a normal myeloid: erythroid ratio; no abnormal cells were seen. The urine contained 15 mg. of protein; the sediment was loaded with white blood cells and contained 1 to 4 red blood cells per high power field and many bacteria.

The blood urea nitrogen was 19 mg.; the blood sugar 100 mg.; the prothrombin activity 56.5 per cent; the total plasma protein was 7 Gm. with 3.9 Gm. of albumin and 3.1 Gm. of globulin; the thymol turbidity was 10; cephalin flocculation reaction was 1 plus; the blood cho-

lesterol was 150 mg. with 76 per cent esters; the alkaline phosphatase was 3.7 and 2.7 units; inorganic phosphorus was 4.7 and 4.0 mg. She had 5 per cent retention of bromsulphalein; the van den Bergh reaction was 0.2 mg. direct, and 0.4 mg. indirect. The stool guaiac test was negative. Serology was negative. Her electrocardiogram was unremarkable.

Roentgenographic Studies

The cholecystogram showed a non-concentrating gallbladder with small stones. Her chest x-ray gave evidence of adhesions in the right costophrenic area but no evidence of active lung or heart disease. The gastrointestinal series showed esophageal varices, a traction diverticulum, ascites, and probably renal calculi at the upper pole of the right kidney. Intravenous pyelogram showed good kidney excretion, probable calcification of mesenteric vessels, irregular calcification in the right kidney and probable stones in the left kidney. The splenoportogram showed marked enlargement of the gastric and coronary veins with esophageal varices.

Hospital Course

On the first hospital day 500 cc. of bloody ascitic fluid were aspirated; the fluid was sterile on culture and negative for malignant cells. On the seventh hospital day a splenectomy was performed but a shunt procedure was deemed inadvisable. The superior mesenteric vein pressure after ligation of the splenic artery was 230 to 250 mm. of water and the coronary vein pressure after splenectomy was 120. The spleen weighed 1,000 grams. The liver appeared normal and biopsy was reported as showing no cirrhosis. The hernia was repaired.

The immediate postoperative state was good. On the second postoperative day the patient passed tarry guaiac-positive stools and was running a low-grade fever. She showed signs of returning ascites. On the eighth postoperative day she had more tarry stools, her systolic blood pressure dropped from 180 to 120, and her hemoglobin fell from 12.1 to 7.5 Gm. in six hours. Her prothrombin was 52 per cent, and her blood urea nitrogen had risen to 85 mg. An esophageal tube was passed to control what appeared to be bleeding varices, and after several units of blood her general condition improved.

On the eleventh postoperative day she suffered another hypotensive episode with bloody drainage from her esophageal tube and liquid tarry stools. She was treated with blood and one unit of fibrinogen. Stool cultures grew a heavy growth of *Staphylococcus aureus,* and her total white count went to 34,000. Her course suddenly went rapidly downhill. The next day her pulse was 150, her extremities were cold and clammy, and she complained of diffuse abdominal pain. Moderate distention was seen; bowel sounds were absent except in the epigastrium. At this stage 100 cc. of bloody fecal fluid were aspirated from the peritoneal cavity. Despite treatment with blood transfusions, intravenous albumin, Neo-Synephrine®, calcium chloride and Chloromycetin® the patient failed to improve and died the following day.

Clinical Discussion

DR. ELLISON: Our patient had the usual childhood diseases, but her life was not too much plagued with illness until she reached the age of 37, when she had attacks of epigastric pain, nausea and vomiting. This continued until the age of 41, when she fell into the hands of a surgeon who, recognizing the symptoms, took out her gallstones and left her gallbladder. A week later she had a short bout with jaundice, which I don't think means anything now as far as her immediate problem is concerned. She was not very well for a period of three months after the jaundice, which makes you wonder whether she did not have a hepatitis of some tpye, but I can't be sure.

The only thing of note in the next 30 years is the fact that at the age of 56 she developed cataracts which apparently became gradually worse and nothing was done about them. She also had developed an umbilical hernia which gradually enlarged over the years. At the age of 68 she complained of abdominal distention, shortness of breath and marked weakness. Her physicians blamed most of her problems on an enlarged spleen and on anemia and treated her with iron until finally, at the age of 70, she was hospitalized with left flank pain, urinary retention, edema and anemia. At the time they thought she probably had a kidney stone and suspected heart disease.

She was treated with 6 units of blood and a low-sodium, low-calorie diet. She lost a lot of weight and I think that is something we have to keep in mind. When patients go on a low-calorie diet and lose weight very easily, one must suspect a maliganancy somewhere. But she did fairly well apparently during this eight-month period until she again noted the onset of abdominal distention and shortness of breath. She had an attack of acute dyspnea with a feeling of oppression over the chest which lying down relieved. Medical men tell me that this can be a fooler. A fellow who is developing a coronary attack with



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mild symptomatology and lies down, usually gets worse rather than better. I did not realize that.

Let us see the things we want to remember from her life history: She still has her gallbladder, her ventral hernia, her enlarged spleen, anemia; has been treated for heart disease; renal calculi; weight loss. That is about what I get out of her past history. Her physical examination is helpful. They did not note that she had an enlarged heart. She had some crackling rales on both sides. She had ascites, a palpable spleen, apparently a normal liver, an umbilical hernia, sacral edema and edema of both legs. This should make us think of some sort of portal hypertension. With her weight loss and ascites you could think of malignancy. With her marked edema, both sacral and of her lower extremities, you have to start thinking of malnutrition.

Laboratory Data

She was not as anemic as everybody said. Her white count was low, and we can start thinking in terms of portal hypertension, enlarged spleen and chronic leukopenia. She apparently had no evidence of any other type of hypersplenism. The urinalysis tells us that she probably still had a chronic pyelonephritis, so we can add that to the list. Her liver profile to all intents and purposes was normal. That is sort of unusual when we are thinking in terms of portal hypertension, isn't it? Now we have to think that this portal hypertension must be extrahepatic and not intrahepatic. So the patient had a splenoportogram.

In a normal splenoportogram you don't see tributaries or collaterals. The splenic vein and portal vein are of normal size and the dye immediately goes into their branches and you see a normal liver.

Our patient showed dilated splenic vein with short gastric vessels branching off. It showed gastric varices and a huge coronary vein. It seems to me that I would interpret this as extrahepatic portal block appearing within the portal vein, and it could very well be a cavernous transformation of the portal vein which is the cause of her esophageal varices and probably the cause of her ultimate demise. Other things which became apparent from her x-ray studies are gallstones, which probably did not bother the patient at all, a large spleen, stones in the right kidney, calcification of the mesenteric vessels or possibly of the portal vein, and varices.

What is the typical symptomatology of an extrahepatic portal block? Ascites, which our patient had; varices which may or may not bleed and be the cause of chronic blood loss and anemia; secondary hypersplenism with leukopenia; edema of the legs; and most important of all, a normal liver function. If the patient has a ventral hernia, it has a tendency to get larger during a period of portal hypertension. I think that all this fits pretty well for our patient and probably explains most of the troubles she had been having.

A week later at surgical operation they apparently found an enlarged spleen and did a splenectomy. If you have a question as to where the obstruction is in your portal system your vein pressure measurements can help you. Normal pressure in all these veins should be less than 190 mm. of water. If you measure the superior mesenteric and it is elevated, your block has to be proximal to it.

About all we can say from the two measurements that are given is that we have confirmed the existence of portal hypertension and have presumably lowered it to normal levels by taking out the spleen. We know this to happen. The only trouble is that it stays normal for periods varying from one day up to nine months, and we can't predict how long it will stay normal. Apparently they were a little hesitant to do a shunt because of the risk to the patient, and probably also because the pressure fell to normal with the spleen out. They did fix the ventral hernia and took a biopsy specimen of the liver, which confirmed our diagnosis of extrahepatic portal block.

Nineteen Days Later She Died

She started to redevelop ascites. Portal hypertension is coming back up. She passed tarry stools. This could also mean an elevation in her portal tension and bleeding. She had a fever of unknown origin, so she was switched from Combiotic® to Chloromycetin. Nothing happened until her eighth postoperative day, when she had voluminous tarry stools and went into shock. Her hemoglobin went from 12.1 to 7 in a six-hour period, and her blood urea nitrogen went to 85. They also suspected that she was bleeding from her varices again and put an esophageal tube in her. This is the tube of death, as far as I can tell. They gave her transfusions, of course, to get her out of this.

On the eleventh day she had her second episode of shock with bleeding. They gave her blood again, and something that I object to—fibrinogen. Since she had a normal liver function, she could make all the fibrinogen she wanted, and the additional fibrinogen just might have caused a mesenteric thrombosis of her gut. They cultured her stool and got pure *Staphylococcus aureus*. So you have to think of staphylococcus enterocolitis. Very rightly she was switched to erythromycin.

On the fourteenth day her white count was

34,000. Dr. Zollinger always used to teach me that there is *one thing* that will cause a white count like this and that is thrombosis of a mesenteric vessel. So we have to think of that, and on the 17th day she had sudden abdominal pain. They tapped her and got bloody fecal material. Did she rupture a gut with the onset of pain? Possibly. Could she have ruptured a site of her gut thrombosed from the fibrinogen she had received? Perhaps. Two days later she died.

What do I think happened to her after surgery? Her elevated portal hypertension appeared again and she had two massive hemorrhages from her varices, and in addition, just to make things worse, she developed a staphylococcus enterocolitis. Several things could have happened from here. She may have ruptured a necrotic bowel and developed a fecal peritonitis. Or with the fibrinogen she received she may have developed a mesenteric thrombosis with infarction of the intestine.

Clinical Diagnosis

1. Cavernous thrombosis of portal vein with portal hypertension.
2. Status post-splenectomy and repair of ventral hernia.
3. Esophageal varicosities with hemorrhage.
4. Staphylococcic enterocolitis.
5. Recent mesenteric artery thrombosis with massive infarction of the intestine.
6. Chronic cholecystitis and cholelithiasis.
7. Bilateral pyelonephritis with nephrolithiasis.

Pathological Diagnosis

1. Phlebosclerosis of portal vein with old portal vein thrombosis.
2. Status post-splenectomy and repair of ventral hernia.
3. Esophageal varicosities with hemorrhage.
4. Recent thrombosis of mesenteric artery with massive infarction of the intestine.
5. Chronic cholecystitis.
6. Bilateral pyelonephritis with nephrolithiasis.

Pathological Discussion

Dr. von Haam: The body was that of an elderly white female weighing approximately 145 lbs. Her abdomen was distended and contained 3,000 cc. of hemorrhagic, cloudy fluid. The peritoneum was deep purple and covered with fibrinous adhesions. The small intestines were distended and showed a bluish black discoloration. The heart was slightly enlarged and firm. The lungs were partly collapsed and edematous. The spleen was absent.

The liver was small, weighing only 1200 grams, but was smooth and mottled. The wall of the portal vein was thickened and the lumen filled with a gray, laminated thrombus. The gallbladder was small and no gallstones were found. The pancreas was small and congested and the vessels contained thrombi. The superior mesenteric artery was completely occluded by a soft recent red thrombus. The esophagus showed distended varices and many small recent bleeding ulcers. The stomach was congested and contained no recent blood.

The small intestines and the ascending colon were deep purple and dilated. The wall showed many recent infarcted areas. The lumen contained dark hemorrhagic material. The adrenals were small. The right kidney was granular and the calyces contained four small stones. The left kidney contained numerous small cysts, a dilated pelvis and a double ureter. The abdominal aorta was severely arteriosclerotic. The sex organs and the urinary bladder appeared normal.

Microscopic Examination

Sections through the spleen removed by surgery showed typical adenofibrosis with hemolytic foci and clumps of white blood cells in the meshwork of the pulp. It was typical of secondary hypersplenism in congestive splenomegaly due to portal hypertension. Sections through the lung showed atelectasis and small recent thrombi in the smaller vessels. The liver showed extensive toxic necrosis recent in nature. The wall of the portal vein showed marked thickening with inflammation of the wall and laminated thrombi. Sections through the mesenteric artery showed a much more recent thrombus with platelet masses and well-preserved red cells. The wall of the affected intestines was extensively infarcted. Both kindneys showed a rather severe degree of pyelonephritis with concretions forming in the tubules.

In summary, we can say that the patient died from massive intestinal infarction due to thrombosis of the mesenteric artery. Dr. Ellison's suggestion that the fibrinogen administered to the patient in hemorrhagic shock may have been responsible for this terminal event is excellent and seems well supported by our findings. The patient's primary disease was due to an old portal vein thrombosis accompanying a chronic pylephlebitis with extrahepatogenous portal hypertension as suggested by our clinical discussant. I want to congratulate Dr. Ellison for his clear and concise discussion of this case and particularly for his day-by-day analysis of the events leading to the death of the patient, with which I am in hearty agreement. I feel certain that the unit of fibrinogen proved to be the "wrong medicine" for this patient.

Low Dosage KYNAR for G.U. Infections

Unusual Antibacterial and Anti-infective Properties. More rapid absorption . . . higher and better sustained plasma concentrations . . . more soluble in acid urine than other sulfonamides . . . freedom from crystalluria and absence of significant accumulation of drug, even in patients with azotemia. [1]

Unprecedented Low Dosage. Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. (1 to 2 tablets) maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides —a notable asset in prolonged therapy. [2]

New Control Over Sulfonamide-sensitive Organisms. KYNEX maintains the prolonged, high tissue concentrations of primary importance in treatment of urinary infections . . . a therapeutic asset toward preventing manifest pyelonephritis as a complication of persistent bacteriuria during pregnancy and puerperium. Maintenance of sterile urine in such patients was accomplished with 1 tablet of KYNEX daily. [3]

KYNEX*

Sulfamethoxypyridazine Lederle



Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

References: 1. Grieble, H. C. and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958. 2. Editorial *New England J. Med.* 258:48-49,1958. 3. Jones, W. F., Jr. and Finland, M., Sulfamethoxypyridazine and Sulfachloropyridazine. *Ann. New York Acad. Sc.* 60:473-483, 1957.

*Reg. U. S. Pat. Off.

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Medical Society Officers Conference . . .

Presidents, Secretaries and Certain Committee Chairmen Attend Program In Columbus, March 2; Meet with Councilors and Other Officers of OSMA

COUNTY Medical Society officers responded well to the opportunity of getting together with their Councilors and other members of The Council on Sunday, March 2, in Columbus. The result was that 65 County Medical Societies were represented, with a total of 164 persons present.

Important sessions of the conference were those in which representatives of the various counties met with their respective Councilors to discuss local matters. An hour was devoted to these conferences and proved a good investment in time judging by the discussions that came out of them.

"Third-Party Medical Care Programs—Ethical and Legal Aspects." This hot problem was ably discussed by Dr. Charles L. Hudson, Cleveland, Past-President of the OSMA and chairman of the Association's Committee on Medical Services.

Dr. Hudson elaborated on the statement of The Council on this subject as published in the January issue of *The Journal* beginning on page 86. He also discussed the numerous conferences that have been held between representatives of the State Association and leaders of organizations that promote medical care programs in Ohio.

Panel of Secretaries

Five men who are right on the front lines in regard to this subject formed a panel and discussed "The Job of the County Medical Society Secretary."

Moderator of the panel was Dr. George N. Spears, Ironton, secretary of the Lawrence County Medical Society. Dr. Spears pointed out that the secretary is a prime force in the local organization, often carrying over his responsibilities from one year to the next.

Dr. Thomas D. Allison, Lima, secretary of the Academy of Medicine of Lima and Allen County, discussed the numerous tasks that fall to the secretary and the development of "ground rules" to meet and deal with situations as they arise.

Dr. John V. Emery, Willard, secretary of the

Principal Speakers Formed This Panel To Answer Questions



Speakers on the program who later formed this panel to answer questions from the audience are, left to right: **Mr. Charles S. Nelson,** Executive Secretary of OSMA; **Dr. George N. Spears,** Secretary of the Lawrence County Medical Society; **Dr. George A. Woodhouse,** OSMA President-Elect, who presided at the afternoon session; **Dr. Ernest B. Howard,** Assistant AMA General Manager; **Dr. Charles L. Hudson,** Past-President of the Association; and **Dr. Robert S. Martin,** OSMA President, who presided at the morning session.

General View of County Society Officers Get-Together



Part of the audience of more than 160 persons who attended the Conference of County Society Officers in Columbus. Sixty-five County Medical Societies were represented.

Huron County Medical Society, discussed qualifications of a secretary. Assuming a few years of practice to make him familiar with medical affairs, the number one qualification is a willingness to undertake the responsibilities, he declared.

Dr. Dale A. Hudson, Piqua, secretary of the Miami County Medical Society, reviewed the red book sent out by the OSMA Headquarters Office to all secretaries. Some of the items in this folder can be passed on to certain committee chairmen, Dr. Hudson said. Others may be ordered in sufficient quantities to be passed on to members. The compilation forms a ready reference for the secretary in convenient form.

Dr. Carl H. Laestar, Portsmouth, secretary of the Scioto County Medical Society, discussed the importance of a suitable meeting place and time. Such a place and time, he said, must take into consideration practice habits of members. He stressed the importance of a period in each meeting to discuss administrative problems. Even if the attendance is small, a brief discussion will give members an opportunity to air their views and give officers a consensus of opinion. He also emphasized the importance of a clear-cut distinction between staff matters and Society matters.

Medicine's Great Challenge

Guest speaker for the occasion was Dr. Ernest B. Howard, Chicago, assistant general manager of the American Medical Association. His talk was on "The Forand Bill—Medicine's Greatest Current Challenge." Dr. Howard stressed the need for a positive approach on the part of the medical profession to the health, welfare and medical needs of the public. We must show the public that we have a better way to promote the general welfare of the people, he stressed. Dr. Howard reminded his hearers that every inroad of the socialists in recent years has been through the Social Security program. If socialized medicine comes to America, he stated, it will come through Social Security. The provisions of the proposed Forand Bill were summarized in the January issue of *The Journal,* page 85.

Mr. Charles S. Nelson, Executive Secretary of

the OSMA, stressed some of the more important events and projects which have been undertaken for 1958 in a talk entitled, "Things To Watch For."

Mr. Nelson re-emphasized the need for continuing close harmony between County Medical Societies and the OSMA. Some of the "things to watch for" include the early collection of dues (technically a physician is not a member of his component organization until his dues for the current year are paid); the coming Primary Election and General Election with close attention to qualifications of candidates.

Unable to be present as scheduled because of illness was Wayne E. Stichter, Toledo, legal counsel. Mr. Stichter had been scheduled to talk on the subject, "How County Medical Societies Can Avoid Legal Pitfalls."

Presiding at the morning sessions was Dr. Robert S. Martin, Zanesville, President of the OSMA, who welcomed County Society officers to the conference. Dr. George A. Woodhouse, Pleasant Hill, OSMA President-Elect, presided over the afternoon sessions.

The program was held at the Deshler-Hilton Hotel where luncheon was served. Final session of the conference was a discussion period during which questions submitted throughout the conference were replied to by a panel consisting of all those who had participated in the program.

Roster of Those Present

Those registered at the conference included the following:

OFFICERS AND COUNCILORS: Robert S. Martin, Zanesville, President; G. A. Woodhouse, Pleasant Hill, President-Elect; Richard L. Meiling, Columbus, Past-President; Geo. J. Hamwi, Columbus, Treasurer; First District Councilor, Frank H. Mayfield, Cincinnati; Second District, R. Dean Dooley, Dayton; Third District, James R. Jarvis, Van Wert; Fourth District, Paul F. Orr, Perrysburg; Fifth District, George W. Petznick, Shaker Heights; Sixth District, C. A. Gustafson, Youngstown; Seventh District, Robert E. Hopkins, Coshocton; Eighth District, William D. Monger, Lancaster; Ninth District, C. L. Pitcher, Portsmouth; Tenth District, Edwin H. Artman, Chillicothe; Eleventh District, H. T. Pease, Wadsworth.

FIRST DISTRICT: **Adams County**—Richard L. Woodyard, Manchester; **Brown County**—Donald L. Domer, Georgetown; Charles H. Maly, Sardinia; **Butler County**—John Perkins and Robert A. Tennant, Middletown; **Clermont County**—Carl A. Minning, Batavia; **Clinton County**—Robert Conard and Roy D. Goodwin, Wilmington; **Hamilton County**—J. Robert Hudson, Clyde S. Roof, and Mr. Edward F. Willenborg, all of Cincinnati; **Warren County**—D. Paul Ward, Pleasant Plain.

(Continued on Page 638)

County Medical Society Secretaries Tell What the Job Is



First-hand information on "The Job of the County Medical Society Secretary," was given by this panel. Secretaries of their respective Societies are, left to right: **Dr. John V. Emery,** Huron County; **Dr. Thomas D. Allison,** Allen County; **Dr. George N. Spears,** Lawrence County; **Dr. Carl H. Laestar,** Scioto County; Dr. **Dale A. Hudson,** Miami County.

These Are Some of the Councilor District Conferences



Conference of First Councilor District. Presiding is **Dr. Frank H. Mayfield,** Cincinnati, Councilor (center, facing camera).



Second District Conference. Presiding, **Dr. R. Dean Dooley,** Dayton, Councilor (to left at head of table).



Third District Conference. Presiding, **Dr. James R. Jarvis,** Councilor, Van Wert, (facing camera with paper in hand).

More District Groups Get Together With Their Councilors



Fourth District Conference. Councilor, **Dr. Paul F. Orr,** Perrysburg, (third man from the left).



Fifth District Conference. Councilor, **Dr. George W. Petznick,** Cleveland, (left, facing camera).

(Roster of Those Present—Cont'd)

SECOND DISTRICT: **Champaign County**—Isador Miller and John K. Pond, Urbana; **Clark County** — Martin J. Cook and E. W. Schilke, Springfield; **Darke County**—E. W. Arnold, New Madison; V. Ray Boli and Maurice Kane, Greenville; **Greene County**—Paul D. Espey and Benjamin F. Lee, Xenia; **Miami County**—Deane B. Armour, Bradford; Paul E. Foy, Troy; Dale A. Hudson, Piqua; **Montgomery County** — A. V. Black, Centerville; Lynne E. Baker, John R. Brown, Mr. Robert F. Freeman, T. L. Light, G. L. Parkin, James W. Priest, Sylvan L. Weinberg, all of Dayton; **Preble County**—E. P. Trittschuh, Lewisburg.

THIRD DISTRICT: **Allen County**—Thomas D. Allison, Roger L. Tecklenberg, W. E. Yingling, all of Lima; **Auglaize County**—E. Y. Kuffner, St. Marys; Michael Rabe, New Bremen; **Crawford County**—T. D. Sawyer, Crestline; **Hancock County** — Frank M. Wiseley, Findlay; **Hardin County**—Floyd M. Elliott, Ada; **Marion County** —Daniel Murphy, Marion; **Wyandot County**—

(Continued on Page 640)

Sixth, Seventh and Eighth District Conferences



Sixth District Conference. Councilor, **Dr. Carl A. Gustafson,** Youngstown, (at head of table).



Seventh District Conference. Councilor, **Dr. Robert E. Hopkins,** Coshocton, (at head of table).



Eighth District Conference. Councilor, **Dr. William D. Monger,** Lancaster, (center).

(Roster of Those Present—Cont'd)

R. L. Garster and Allen F. Murphy, Upper Sandusky.

FOURTH DISTRICT: **Henry County**—Thomas F. Tabler, Holgate; **Lucas County**—Henry D. Cook, Mr. Robert W. Elwell, Harvey Gunderson, all of Toledo; **Ottawa County**—Cyrus R. Wood, Port Clinton; **Putnam County**—James B. Overmier, Leipsic; **Sandusky County**—E. C. Swint, Fremont; **Wood County**—S. J. Smith, Bowling Green.

FIFTH DISTRICT: **Ashtabula County**—Walter J. Brown, Conneaut; Lewis H. Roth, Geneva; **Cuyahoga County**—John H. Budd, Eduard Eichner, Harry A. Haller, Charles L. Hudson, C. R. Jablonoski, Albert L. Jones, John A. Kenney, Jr., Thomas D. Kinney, Mr. Robert A. Lang, and Paul A. Mielcarek, all of Cleveland; **Geauga County**—Alton W. Behm, Chardon.

SIXTH DISTRICT: **Portage County**—R. P. McCormick, Ravenna; F. R. McKeehan and Don P. Van Dyke, Kent; **Stark County**—Gervis Brady and Mr. E. M. Sprunger, Canton; **Summit County**—Arthur Dobkin and Mr. S. H. Mountcastle, Akron; Harold E. Muller, Barberton; **Trumbull County**—Paul E. Noonan and Aubrey L. Sparks, Warren; Raymond H. Ralston, Niles.

SEVENTH DISTRICT: **Belmont County**—David Danenberg, Bridgeport; B. C. Diefenbach, Martins Ferry; **Carroll County**—Carl A. Lincke, Carrollton; **Coshocton County**—G. W. Stelzner, Coshocton; **Jefferson County**—C. F. Goll, Steubenville; **Tuscarawas County**—Jay W. Calhoon, Uhrichsville; J. W. Hamilton, Dover.

EIGHTH DISTRICT: **Athens County**—C. R. Hoskins, Athens; D. R. Johnson, Nelsonville; **Fairfield County**—A. B. Van Gundy, Lancaster; **Guernsey County**—H. D. Miller and Thomas D. Swan, Cambridge; **Licking County**—Kurt J. Fleisch, John E. Hendricks, and William J. Kennedy, all of Newark; **Muskingum County**—L. P. Cassady, East Fultonham; William A. Knapp, Zanesville; **Perry County**—O. D. Ball, New Lexington; Charles E. Bope, Somerset.

NINTH DISTRICT: **Gallia County**—Ralph B. Burner, Gallipolis; **Jackson County**—Brinton J. Allison, Oak Hill; **Lawrence County**—Harry Nenni, and George N. Spears, Ironton; **Pike County**—Paul Jones, Stockdale; **Scioto County**—Clyde M. Fitch and Carl H. Laestar, Portsmouth.

TENTH DISTRICT: **Delaware County**—Mary K. Kuhn, Ashley; **Franklin County**—Jonathan Forman, P. B. Hardymon, Martin P. Sayers, Thomas E. Shaffer, C. C. Sherburne, Mr. William Webb, Jr., and H. P. Worstell, all of Columbus; J. L. Henry, Grove City, **Knox County**—James C. McLarnan and Clinton W. Trott, Mount Vernon; **Pickaway County**—E. L. Montgomery and Frank R. Moore, Circleville; **Ross County**—Lewis W. Coppel, W. M. Garrett, Robert E. Quinn, and Robert E. Swank, all of Chillicothe; **Union County**—Fred Callaway, Marysville; Herman E. Karrer, Plain City.

ELEVENTH DISTRICT: **Ashland County**—Myron A. Shilling, Ashland; **Erie County**—W. E. Birmingham, Edward Gillette, Jr., D. R. Lehrer, and E. J. Meckstroth, all of Sandusky; **Holmes County**—O. F. Patterson, Millersburg; **Huron County**—John V. Emery, Willard; **Lorain County**—G. R. Wiseman, Amherst; L. C. Meredith and Ben V. Myers, Elyria; P. J. Kopsch and Denis Radefeld, Lorain; O. H. Schettler, Oberlin; **Medina County**—Edward A. Ernst and W. G. Halley, Lodi; N. J. M. Klotz, Wadsworth; **Richland County**—C. F. Curtiss, Bellville; Charles R. Keller and Harry Wain, Mansfield; **Wayne County**—James E. Robertson, Wooster.

OTHERS: Ernest B. Howard, Chicago, Illinois; Messrs. Nelson, Saville, Page, Moore, and Edgar of the OSMA executive staff; Mr. Charles H. Coghlan, OMI, Columbus.

Fort Steuben Academy Holds Programs

"Management of Common Dermatosis" was the subject for the March 11 dinner meeting of the Fort Steuben Academy of Medicine in Steubenville. Speakers were Dr. Harry M. Robinson, Jr., professor and head of the Division of Dermatology, University of Maryland School of Medicine, and Dr. Howard Phillips, medical staff, Ohio Valley Hospital, Wheeling, W. Va.

On April 8 the subject, "Osteoid Osteomas," was discussed by Dr. T. C. Thompson, surgeon-in-chief, Hospital of Special Surgery, New York City; and Dr. John Yobbagy, Department of Roentgenology, Gill Memorial Hospital, Steubenville.

Tuberculosis Groups To Meet in Philadelphia, May 19-22

The annual meeting of the National Tuberculosis Association and its medical section, the American Trudeau Society, will be held in Philadelphia, Pa., from May 19 to May 22. Sessions will be at the Convention Hall and the Bellevue-Stratford will be headquarters hotel. Details may be obtained by writing the National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.

Ninth, Tenth and Eleventh District Groups Confer



Ninth District Conference. Councilor, **Dr. C. L. Pitcher,** Portsmouth, (center).



Tenth District Conference. Councilor, **Dr. Edwin H. Artman,** Chillicothe, (center at head of table).



Eleventh District Conference. Councilor, **Dr. H. T. Pease,** Wadsworth (center).

Council on Health Care of Aged . . .

Organized on National Basis by AMA. Hospital and Dental Associations and Nursing Home Organization To Grapple With Problems of the Aged

THE foundation has been laid by some of the most important organizations in the health field to solve the problem of the health care of the aged.

For this purpose the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association have established the Joint Council to Improve the Health Care of the Aged.

Objectives

Objectives of the council, the formation of which has been under consideration for some time by the sponsoring groups, were announced as:

"(1) To identify and analyze the health needs of the aged; (2) to appraise available health resources for the aged; and (3) to develop programs to foster the best possible health care for the aged regardless of their economic status."

The Joint Council to Improve the Health Care of the Aged is made up of three representatives of each sponsoring organization.

Fact-Finding Job

One of the first jobs of the council will be to determine exactly what are the health problems of the aged. Studies have been underway for the past several years by the organizations making up the council, but now, through joint efforts, research will be intensified and projects for meeting the problem will be activated as rapidly as possible. The council will be the agency through which the efforts of the sponsoring member organizations will be coordinated to solve the health problems of the aged.

The sponsoring organizations pointed out that the need for new programs in this field is accented by the fact that the life expectancy of individuals has been constantly increasing in recent years. In 1935 life expectancy in the United States was an average 60.2 years. The most recent figure indicates the average life expectancy now to be 70.0 years.

Will Develop Programs

The council will have as one of its principal immediate projects the development of programs and facilities to be tailored to the health needs and finances of the aged.

Another facet of the council's broad-range program will be to work closely with health insurance groups in an effort to improve the coverage of the aged and to see that their insurance dollars go further.

Job for Local and State Areas

It is the belief of the Joint Council to Improve the Health Care of the Aged that much can be done for older people by the states and communities, and the council will endeavor to stimulate the activities at these levels of government.

Special research projects are contemplated by each of the organizations supporting the council. This research will then be pooled and programs developed to meet the health needs of the aged. The ultimate goal is to provide adequate health care at reasonable costs.

Caribbean Seminar-Cruise Sponsored by Ohio State College of Medicine

Ohio State University College of Medicine is sponsoring a Postgraduate Medical Seminar-Cruise. Aboard the *M/S Stockholm,* the group will sail from Wilmington, N. C., on November 11 and visit points in the Caribbean, over a period of fifteen days.

An excellent program has been arranged, Dr. N. Paul Hudson, assistant dean for postgraduate medical education, announced. The following faculty has been announced: Drs. Charles A. Doan, dean of the College of Medicine and professor in the Department of Medicine; Emmerich von Haam, professor and chairman of the Department of Surgery; Geo. J. Hamwi, associate professor in medicine; Thomas E. Shaffer, professor in pediatrics; Joseph M. Ryan, associate professor in medicine; Kenneth H. Abbott, clinical assistant professor in surgery; and Dr. Hudson.

This medical seminar constitutes 30 hours acceptable Category I postgraduate requirements of the American Academy of General Practice.

Travel agency in charge is Allen Travel Service, Inc., 565 Fifth Ave., New York 17, N. Y. A list of topics to be discussed and other information may be obtained by writing to the office of the Dean, College of Medicine, Ohio State University, Columbus 10, Ohio.

Results of Election at Annual Meeting in Cincinnati; Detailed Reports To Appear In June Issue of The Journal

BECAUSE of the necessity of meeting publication deadlines, *The Journal* could not carry a complete report on the 1958 Annual Meeting, held April 15-17, in Cincinnati, in this issue. Details on the very successful Cincinnati meeting will be published in the June issue.

However, the following facts regarding the election of officers, Councilors and AMA Delegates are presented here, in advance of the detailed Annual Meeting report in next month's *Journal*.

Dr. George A. Woodhouse, Pleasant Hill, was installed as president, succeeding Dr. Robert S. Martin, Zanesville, who remains on The Council for another year.

The new President-Elect is Dr. Frank H. Mayfield, Cincinnati, who had served as Councilor of the First District. He will take over the presidency at the 1959 Annual Meeting. Dr. George J. Hamwi, Columbus, was re-elected Treasurer for a three-year term.

The following were elected to The Council for the first time: Dr. Charles W. Hoyt, Cincinnati, representing the First District, and Dr. Floyd M. Elliott, Ada, representing the Third District. Dr. Hoyt succeeds Dr. Mayfield on The Council. Dr. Elliott takes the place of Dr. James R. Jarvis, Van Wert, who had served as Councilor for three consecutive terms of two years each, the maximum allowed by the Constitution and By-Laws.

Councilors re-elected were: Dr. George Petznick, Cleveland, Fifth District; Dr. Robert E. Hopkins, Coshocton, Seventh District; Dr. Carter L. Pitcher, Portsmouth, Ninth District; and Dr. H. T. Pease, Wadsworth, Eleventh District. Hold-over Councilors are: Dr. R. Dean Dooley, Dayton, Second District; Dr. Paul F. Orr, Perrysburg, Fourth District; Dr. C. A. Gustafson, Youngstown, Sixth District; Dr. William D. Monger, Lancaster, Eighth District; and Edwin H. Artman, Chillicothe, Tenth District.

The following were re-elected Delegates to the AMA: Dr. Charles L. Hudson, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. George A. Woodhouse, Pleasant Hill; and Dr. Herbert B. Wright, Cleveland. Their respective alternates elected are: Dr. H. T. Pease, Wadsworth; Dr. Robert S. Martin, Zanesville; Dr. R. Dean Dooley, Dayton; and Dr. Fred W. Dixon, Cleveland.

Hold-over AMA delegates and alternates are Dr. Paul A. Davis, Akron, and Dr. Edmund K. Yantes, Wilmington, his alternate; Dr. Carll S. Mundy, Toledo, and Dr. Paul F. Orr, Perrysburg, his alternate; Dr. L. H. Schriver, Cincinnati, and Dr. Charles A. Sebastian, Cincinnati, his alternate; Dr. C. C. Sherburne, Columbus, and Dr. Richard L. Meiling, Columbus, his alternate.

The 1959 meeting will be held in Columbus, the week of April 19.

Visiting Pediatricians Attend Columbus Clinic Day

The Invitation Clinic Day Program of the 15th Annual Assembly of the Central Surgical Association was held at University and Children's Hospitals in Columbus recently. Among guest physicians who participated in the clinic were the following: Dr. D. R. Murphy, Montreal Children's Hospital; Dr. C. N. Weller, Detroit Children's Hospital, and Dr. C. C. Ferguson, Winnipeg Children's Hospital.

Trudeau School of Tuberculosis Scheduled at Saranac Lake

The Trudeau School of Tuberculosis and Other Pulmonary Diseases will hold its 43rd session in Saranac Lake, N. Y., June 2-June 20. This annual postgraduate course, conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation, provides instruction at a minimal tuition of $100 for a three weeks session. Inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, N. Y.

Federated Fund Drives . . .

Report of Special OSMA Committee on This Subject Is Given as Approved By The Council; How Subject Relates to Medical Societies and Doctors

SUGGESTED procedures and activities to be followed in the formation of a federated health organization and a federated health fund-raising program have been outlined in the following report of a special OSMA committee. The report, compiled by the Committee on Relationship Between Medical Societies and Voluntary Health Organizations, was approved by The Council on December 15, 1957.

Copies of the report have been distributed to County Medical Societies.

Members of the special committee which worked for more than a year on this question is composed of the following: A. Macon Leigh, Cleveland, Chairman; Charles L. Leedham, Cleveland; Norman O. Rothermich, Columbus; Charles A. Sebastian, Cincinnati; Theodore L. Light, Dayton; Robert G. McCready, Akron; Max T. Schnitker, Toledo; Harry Wain, Mansfield; David L. Steiner, Lima; Carl F. Goll, Steubenville; Harold E. McDonald, Elyria; Paul A. Davis, Akron; Michael C. Kolczun, Lorain.

The text of the committee's report which explains the committee's assignment and its recommendations, follows:

* * *

Text of Committee Report

The mission of this committee has been to carry out the provisions of the following resolutions adopted by the House of Delegates of the Ohio State Medical Association:

Amended Substitute Resolution O, adopted at the 1956 Annual Meeting, held April 10-12, in Cleveland, Ohio:

> "WHEREAS, More and more health agencies are being formed to attract voluntary funds to be used in fighting specific diseases, causing duplication of manpower and overhead,
>
> "BE IT RESOLVED, That a committee be appointed by the Ohio State Medical Association to gather facts and experiences on this subject which will be made available to County Medical Societies giving consideration to the question."

Substitute Resolution D, adopted at the 1957 Annual Meeting, held May 13-16, in Columbus, Ohio:

> "WHEREAS, Single disease health agencies emphasize the great emotional appeal of certain diseases and thus tend to distort their true relation to total health, and
>
> "WHEREAS, Doctors of Medicine, in the final analysis, are responsible for the health of the nation and any voluntary health agency expenditure or health agency fund-raising campaign that is not in conformity with the prevailing policy of their medical society can be detrimental to the total good, and
>
> "WHEREAS, Several communities have already organized a federated health drive, therefore
>
> "BE IT RESOLVED, First, that the Ohio State Medical Association House of Delegates approve in principle the formation of a federation at the local level embracing all voluntary health agencies and the raising of funds for such federation through a single drive; and
>
> "Second, that the Ohio State Medical Association's special committee on Relationship Between Medical Societies and Voluntary Health Organizations be urged to prepare recommendations which might assist component county medical societies in achievement of such federation, if there exists a desire on the part of lay and physician-citizens of the county for such federation."

Assignments of This Committee

As a format for its work, the committee agreed upon these specific assignments:

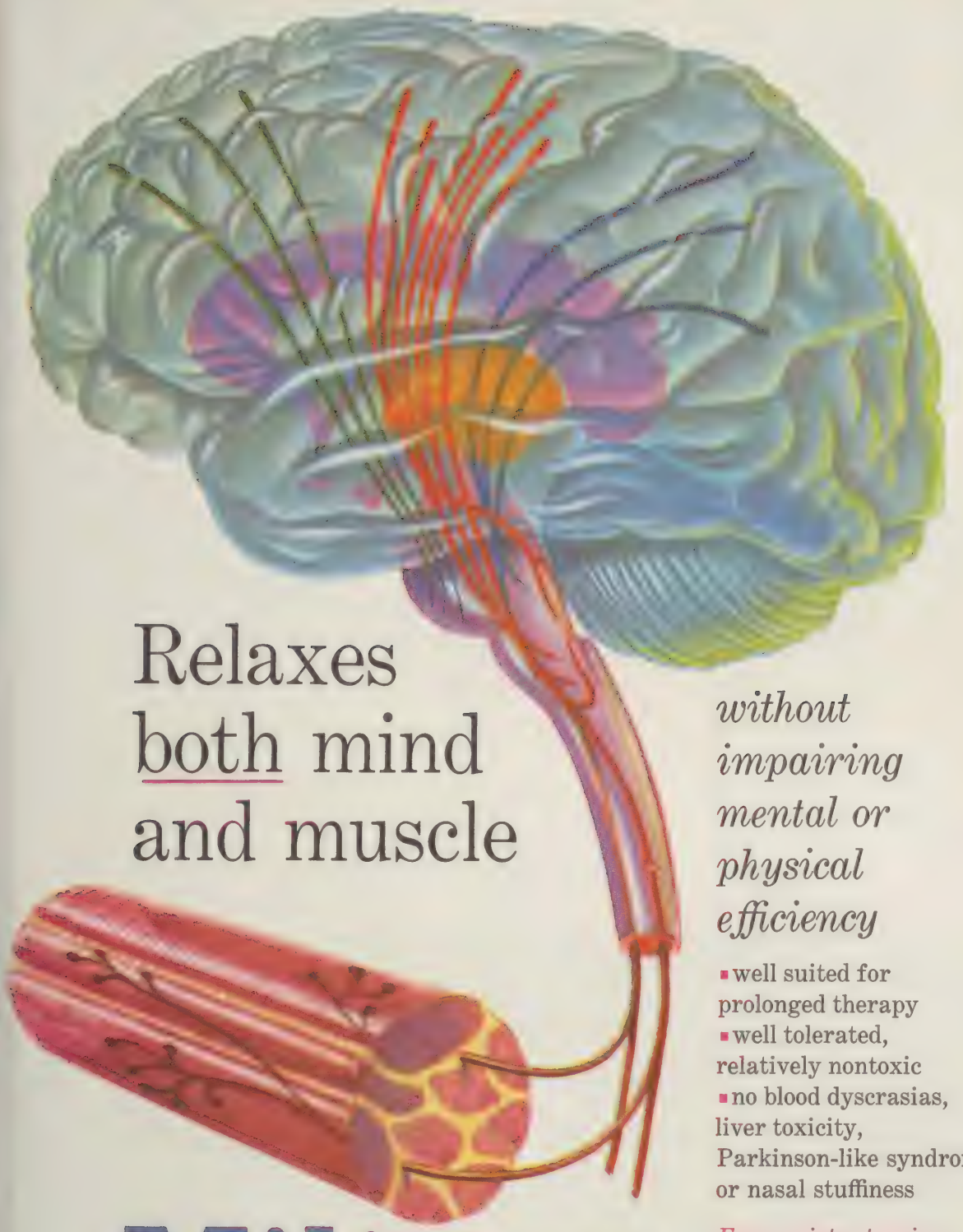
1. To draft a report suggesting procedures and activities which could be followed if the formation of a federated health organization and federated health fund-raising program is contemplated and to make such recommendations available to county medical societies, and other groups of physicians, on request.

2. To assemble information on programs in effect in various communities throughout the country, in packet form and lend such packets to county medical societies and other groups of physicians, on request, to guide them in their local planning.

This report completes Assignment No. 1. Assignment No. 2 has been partially completed. The committee will continue to supervise the accumulation of additional material for the loan packets as it becomes available, and advise the Columbus Office of the Association on matters arising in connection with the distribution of the packets.

Must Be Grass Roots Interest

It is not the intent of this committee to engage in any debate on why a community should or should not form a federated health organization and federated health fund raising program. That question must be answered by each community itself. As stated by J. D. Benefiel, Director of the Community Chest and Councils of America ad-



Relaxes both mind and muscle

without impairing mental or physical efficiency

- well suited for prolonged therapy
- well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness

For anxiety, tension and muscle spasm in everyday practice.

Supplied:
400 mg. scored tablets,
200 mg. sugar-coated tablets.
Usual dosage:
One or two
400 mg. tablets t.i.d.

Miltown®

2-methyl-2-n-propyl-1,3-propanediol dicarbamate

TRANQUILIZER WITH MUSCLE-RELAXANT ACTION



THE ORIGINAL MEPROBAMATE
DISCOVERED & INTRODUCED BY
WALLACE LABORATORIES
NEW BRUNSWICK, NEW JERSEY

CM-6590

AN IMPORTANT ADVANCE IN MENOPAUSAL THERAPY

Because it replaces *half* control with *full* control.

Because it treats the *whole* menopausal syndrome.

Because *one* prescription manages *both* the psychic and somatic symptoms.

SUPPLIED: Bottles of 60 tablets.
Each tablet contains:

MILTOWN® (meprobamate, Wallace) ..... **400 mg.**
2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate.

Conjugated Estrogens (equine) ..... **0.4 mg.**

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

Samples and literature on request.

Two-dimensional treatment of the menopause

Milprem*

MILTOWN®
A Proven Tranquilizer + CONJUGATED ESTROGENS (EQUINE)
A Proven Estrogen

WALLACE LABORATORIES, *New Brunswick, N. J.*
who discovered and introduced Miltown, the original meprobamate.

*TRADE-MARK



visory campaign division and quoted in an article appearing in the September, 1955 issue of *Nation's Business*:

> "A United Fund is not something to be initiated from the top down. It should be a grass roots development. Every community has its own personality, its own profile, its own problems. The United Fund is not a uniform mass production product. It has to be custom built to meet the specifications of each city, or town, or rural area. It should not be tried until there is wide community acceptance for it—until a state of readiness exists."

Starting the Wheels

Assuming that there may exist a spark of interest in studying, at least, the possibilities of establishing a federated health program and united health fund in the community, what steps might be taken to start the wheels of organization into motion?

This point is well covered in the *Nation's Business* article previously referred to. Commenting on the organization of a united health fund and federated program in Stamford, Conn., the article points out how the subject was kicked off in that city, in the following paragraph:

> "Last year at a citizens dinner, representatives of industry, commerce, labor, the clergy, schools, the professions, local health and welfare agencies, agreed that the Chamber of Commerce should explore the United Fund idea."

Stamford did organize a United Fund as an outgrowth of that dinner meeting, the article reveals. Any other community can take steps similar to those taken by the people of Stamford and their leaders, if "a state of readiness exists."

Educational Material

If education of the community to the concept of a federated health organization and united health fund is deemed necessary, advice and material may be secured from any number of the more than 1,000 areas which have united funds and from the fewer communities which have established united or federated health foundations within the framework of an overall community chest and united fund program.

Selected materials on certain programs throughout the country will be found in the packet which this committee has assembled and will make available on request to county medical societies and other groups of interested physicians.

Alternative Types of Programs

When civic leaders are convinced that the community wants to do something to bring about a change in the "giving programs" a decision must be made as to what shall be substituted for the existing situation.

Following is a summary of various programs which might be considered. It should be kept in mind that although one of these may be the answer to the problems existing in a certain community, it may not be the solution for the next community. There is no one formula applicable to all communities alike, as community requirements, conditions and sentiments must be taken into account.

1. One community organization and program for bringing together in integrated fashion all planning and financing of community health and welfare activities. This idea of united planning and united giving, one goal, one fund drive is considered by certain groups seeking a change as the ideal plan. However, they concede it is difficult to attain because of the refusal of some agencies to cooperate. In fact, no program as all-inclusive as this has been established.

2. One community organization and program, including a united fund drive, for most of the health and welfare activities of the community, leaving the responsibility of fund-raising and promotion for their own programs entirely in the hands of those agencies who do not participate in the united appeals program.

3. A federated health organization consisting of representatives of all—or most—of the voluntary health agencies carrying on programs in the community, organized outside the framework of the local Community Chest or United Fund, to promote the activities of the federated agencies and conduct a single united health agency drive for funds entirely divorced from the united appeals campaign for money for welfare agencies.

4. A united health foundation operating within the framework of the local Community Chest and United Fund which receives most of its financial support from the United Fund and assumes the responsibilities for allocating health funds for activities such as medical research, health education, rehabilitation and direct services for the physically or mentally ill.

5. A program patterned after the policy of the Federal Government with regard to solicitation of funds among Federal civilian and military personnel for health and welfare organizations. Briefly, the Federal plan provides for not more than three solicitation periods each year and in cases where communities have a united fund serving all recognized agencies, only one solicitation a year. The three solicitations cover the following categories: (1) Community Chest; (2) American Red Cross; (3) national health agencies.

Investigating and Reporting Plan

An organized charity appeals investigating and reporting service to screen agencies and their

activities and make this information available to the money givers of the community should be set up in each area. This mechanism can be of invaluable assistance to the administrators of any one of the five programs referred to above. It is something needed in each community even though the community may have no organized program for raising and distributing funds for welfare and health activities, as the individual givers themselves do not have the resources to assemble and analyze accurate data about the many varied groups seeking their financial support.

The Profession and Voluntary Health Agencies

Before getting into the details pertaining to the formation of a local federated health organization and the raising of money for such an organization, interested local groups should become familiar with the kinds and character of the many voluntary agencies, devoted wholly or in part to health promotion. Also, they should understand the relationship which should exist between the voluntary health agencies and the medical profession.

The Committee on Relationships Between Medicine and Allied Health Agencies of the American Medical Association offers the following observations:

> "The voluntary health agency is now a recognized community function, and most agencies merit medical society support of their objectives, though the medical society, in some instances, might press for changes in policy or procedure.
>
> "Medical societies and voluntary health agencies have mutual obligations. Medical societies should participate and when desired give agencies advice and counsel on the medical and civic aspects of community needs. Voluntary health agencies should establish liaison with the medical society and frame their programs to conform to sound medical practice.
>
> "Physicians should support voluntary health agencies within their sphere of interest, and recognize whether their role is an official representative of the medical society, interested physician, or private citizen."

This committee (Ohio State Medical Association committee) believes one additional point should be added to the above summary:

> A medical society should not hesitate to refuse endorsement and support to any voluntary health agency if the society believes the program of the agency is unnecessary as proven by substantial evidence or that the agency's program is a duplication of activities being properly carried out by another agency or group of agencies.

Nature of Voluntary Health Agencies

A review of the AMA committee's report and study of data assembled from other sources reveal that agencies concerned with health vary widely in organization, objectives, means for attaining objectives, fund raising methods, membership, and relationship of groups at national, state and local levels. Their principal characteristics are:

A nongovernmental association of citizens, with

A common goal or interest, usually the prevention and control of some disease or infirmity, which

Gathers voluntary contributions, gifts, memorials, and memberships, and

Expends its resources in ways decided by its own governing body, most often for public and professional education, medical and basic science research, and in a number of instances the underwriting of medical care, and which

May begin new fields of work or develop new administrative procedure at will, since it has the capacity to change program quickly to meet recognized needs.

Classification as to Types

Community agencies interested in health, including the voluntary health agency, can be classified into the following types:

1. The local subsidiaries of a national agency concerned with a single disease condition which uses their funds primarily for health education of the public, professional education, research and in some instances, medical care. Examples of such organizations are the National Tuberculosis Association, the American Cancer Society, and the National Foundation for Infantile Paralysis.

2. The local subsidiaries of national agencies concerned with a certain group of people having common problems which may be the result of a variety of related diseases. Among these are such agencies as the National Society for Crippled Children and Adults and the National Association for Mental Health.

3. Local subsidiaries of national civic betterment organizations that become interested in short-term preventive medicine or medical care problems. Among these are the national civic organizations such as Rotary, Lions and Kiwanis, business groups such as the Chamber of Commerce, academic fraternities and sororities and women's organizations.

4. Locally organized groups often now affiliated with a national health agency, such as the auxiliary groups supporting local hospitals or clinics, infant welfare societies, local health councils, and social agencies in the fields of family welfare, adoptive placements, family counseling and various youth activities.

5. Community coordinating groups such as welfare councils, health councils, community chests and similar groups engaged in community planning, in administrative research and in the dis-

tribution of money gathered through federated giving.

Voluntary Agency Evaluation

The AMA committee in its report made these pertinent observations:

> "The medical society is dedicated to maintenance of health in the communities its members serve. It, therefore, has an interest in and an implied responsibility for citizen groups who profess a similar dedication. Any agency that conducts health education, research, and service for the prevention of disease and the rehabilitation of the crippled, therefore, becomes an object for medical society consideration.
>
> "The medical society approach to any agency should be friendly, since these agencies intend to promote health through support of sound medical practice. It should also be constructively critical, since occasionally uninformed enthusiasts can make mistakes which distort even well planned policy."

Questions To Be Answered

Here are some questions which should be asked in the evaluation of local voluntary health agencies:

What relation does the local voluntary agency have to a similar state or national agency? Is it a subsidiary chapter, affiliate or independent competitor?

Why was it started in this community? Who started it and what interests are promoting it?

Are the purposes and stated objectives of the agency medically justifiable, and in accord with the program proposed by the agency?

Is the fund goal realistic when related to community needs and the anticipated over-all program of the agency at the local, state and national levels?

Is the cost of fund raising and administration reasonable in relation to expenditures for the stated objectives?

Are the educational and promotional materials medically correct, ethically presented, in good taste, and educationally sound?

Can the expenditures allocated for research be justified by morbidity and mortality incidence and by local, state and national research needs?

How are expenditures for service related to needs for such service and to the established patterns for medical care?

Mutual Obligations Between Medical Societies and Voluntary Health Agencies

The AMA committee in its report made some excellent suggestions on the recognition by the medical society and the local health agencies of mutual obligations and mutual understanding. Following were the recommendations offered:

> "Liaison should be arranged between medical societies and health agencies by the selection of physician members of the agencies' governing bodies from physicians suggested by, or known to be acceptable to, the medical society.
>
> "The medical society and the health agency should jointly establish basic policies regarding medical care, preventive medicine and all matters involving physicians and their relations to the agency, its members, and its clients.
>
> "There should be cooperative program planning in terms of local, state, and national needs and joint evaluation of accomplishments.
>
> "An agency should comply with the "Principles of Ethics and Fund Raising" formulated by the National Social Welfare Assembly and be willing to have its accounting procedures audited by appropriate auditors in order to establish confidence in its financial integrity.
>
> "There should be mutual exchange of information and opinion so as to permit the medical society and the agency to understand and accept each other's policy and practice."

Role of Individual Physicians In Relation to Voluntary Health Agencies

The individual physician plays four separate but related roles when he becomes affiliated with a voluntary health agency or other voluntary organization concerned with a phase of preventive medicine or medical care.

He may be delegated as an official representative of his medical association, in which case he acts for the medical society expressing the consensus of his colleagues.

He may be called on by an agency to serve it as a physician in ways suggested by his specific professional interest.

Because of his interests, he may seek membership on his own accord and become active in an agency's program.

As a private citizen interested in his community he may use a health agency as the medium for public service, regardless of his profession.

Commenting on the roles of physicians, the AMA committee said:

> "The obligations of these roles are quite different. Both the physician and the voluntary health agency he is serving must recognize the particular role being played. A physician selected by a voluntary agency to serve on its board serves as an individual. He may know medical society policy but has no authority to speak for the medical society unless granted that authority by action of the medical society. Physician membership on a board of directors is desirable and is to be encouraged even though such members represent the medical society only in an informal way and not as its official spokesman."

Packet Available

In order to carry out Purpose No. 2 stated at the beginning of this report, the committee has assembled a packet of material of information from various sources which may be of value to local medical groups which are studying ways and means of revamping local welfare and health fund raising programs.

This packet will be made available on a loan basis, without cost, to a County Medical Society requesting the packet in writing from the Columbus Office.

Physical Exams for Workers . . .

Detailed Report, Including Standards, Principles and Procedures, Adopted Recently by Mahoning and Trumbull County Medical Societies

"IT represents a realistic approach to a vexing problem and is designed to obviate the formation of clinics by groups who would employ medical directors and employ physicians on an hourly scale to perform examination which can well be carried out by practicing physicians."

The above statement appeared on a letter which was sent out recently to the members of the Mahoning County Medical Society (Youngstown) over the signature of Dr. Stephen W. Ondash, at that time president of the society.

The "it" referred to a report of the Industrial Health Committee of the society. The report later was officially adopted by the society and policies and recommendations contained therein are now in effect. An identical report was adopted by the Trumbull County Medical Society—an adjoining county society.

Believing that other county medical societies—especially societies in industrial areas—may find the report of interest and may want to use some of the recommendations enumerated as the basis for study and action, *The Journal* is publishing herewith the complete report and the forms referred to in the report.

* * *

Text of Report

In a preliminary report published previously the committee of which I am the chairman detailed the reasons for its formation and briefly it was as follows. There was a demand from our membership for clear cut information on behavior when asked by industry, or unions, or groups of unions to act as medical director or as an examiner for clinics already in operation or contemplated. It is well known that some of our members have already been approached for participation and, not wishing to transgress any policy of its society, are raising many questions, some already aired on the floor of the society.

The committee has given the problem exhaustive study and has reached the following conclusions:

There is need for the examination of "well" individuals in industry. Furthermore, such examinations would be of profit to the individual, to the industry and to the community. Accordingly, members of our society must be prepared to participate in a manner acceptable to themselves and to those agencies requesting medical services.

Participation must, however, be on terms acceptable to the common good of the membership and must accede to the spirit of patient-doctor relationship so necessary to effect individualized, thorough and exhaustive evaluation of the individual. The outline of an acceptable plan will enable all of us to act without challenge and furthermore discourage undesirable plans of industry and unions to expand benefits without a consideration for those rendering the service, namely the physician. In other words there will be no opportunity for placing the physician in the position of a pawn to be pushed about at will.

Principles Listed

The examination must be on a voluntary basis.

That a uniform type of history and physical examination be evolved such as will serve as basic standards. This has been worked out.

That the scope of the examination can be categorized to meet the desired needs of those underwriting the examination.

That uniform costs be proposed for such examinations and this has been done.

That the results of such examination be kept in confidence unless the condition presents a hazard to the industry.

That the examining physician must be a member of the medical society in good standing.

That the individual be examined by a physician of his choice. If his physician does not prefer to do the basic exam—that he be forwarded a copy of the examinations as performed by any other participating physician of our society.

That a committee of the society supervise the examination.

That a copy of findings should be available to the medical director of the responsible agency initiating the action.

Types of Examinations

Two general types of examinations have been proposed and they would be as follows:

A) General Examination
   1. Check off history and examination similar to attached form.
   2. Urinalysis and hemoglobin determination.

B) Executive Type Examination
   1. Dictated history and physical examination.

(Text Continued on Page 650)

HISTORY FORM

NAME_____ DATE OF BIRTH_____ MALE___ FEMALE___

Each applicant for employment is requested to answer the questions below so that he may be assigned to work with safety for himself and his fellow workers. If disabilities or deficiencies are present, please give details under "comments" at bottom.

PART 1.

NAME OF FAMILY DOCTOR _____

A. Do you have, or have you had, any of the following:

	Please Check Yes	No		Please Check Yes	No
1. High Blood Pressure			13. Broken Bones		
2. Low Blood Pressure			14. Rheumatism-Arthritis		
3. Heart Disease			15. Flat Feet		
4. Lung Disease			16. Anemia		
5. Kidney Disease			17. Diabetes		
6. Stomach Ulcers			18. Tumor, growth, cyst or Cancer		
7. Hernia or Rupture			19. Venereal Disease		
8. Fainting Spells			20. Skin Disease		
9. Convulsions or Fits			21. Asthma or Hay Fever		
10. Back Trouble			22. Surgical Operations		
11. Head Injury			23. Serious Illnesses		
12. Any type Nervous or Mental Trouble			24. For Women to Answer Only: (a) Female disorders		
(a) Do nervous disorders run in your family			(b) Are you pregnant now		

PART 2.

	Please Check Yes	No
A. Has any member of the immediate family ever had— Diabetes		
Tuberculosis		
Insanity		
Kidney Disease		
B. Have you ever received Workmen's Compensation Benefits?		
C. Do you have any condition which may require special work assignment?		
D. Have you had any military service?		
Overseas duty? (Where)		
E. Have you ever been rejected or limited for Military Service?		
F. Did you receive any disability payments (from Veterans Administration)?		
G. Did you receive a Medical Discharge from Military Service?		
H. Have you ever been hospitalized? (Why?)		
I. Have you any present-day complaints referable to your health?		
J. Have you ever been examined for employment by this Company?		

COMMENTS ON THE ABOVE QUESTIONS: _____

I have read and understand the questions above and have answered them voluntarily and truthfully to the best of my knowledge. I agree to such future examination as may be requested by the Company. I further understand that any falsification on my part shall be sufficient cause for discharge from_____

I also authorize any physician or practitioner who has attended me, or may attend me while I am employed here, for any disease or ailment, or any hospital, clinic, or sanitarium, which has admitted me for treatment, to give full particulars to_____ to whom I am making or have made, application for employment.

DATE_____ SIGNATURE_____

PHYSICAL EXAMINATION

NAME_____ DATE _____

Ht._____ Wt._____ B. P._____ Pulse_____

	Normal	Abnormal
1. Eyes: Rt.____ Lt.____ c Gl. Rt.____ Lt.____		
2. Color Blindness		
3. Phys. Appear.		
4. Posture		
5. Scalp		
6. Nose		
7. Hearing		
8. Mouth		
9. Teeth		
10. Thyroid		
11. Lungs		
12. Heart		
13. Circulatory		
14. Abdomen		
15. Rings		
16. Hernia		
17. Varicocele		
18. Hydrocele		
19. Extremities: Upper		
Lower		
20. Flat Feet: Degree		
21. Athlete's Foot		
22. Varicose Veins (Degree)		
23. Back: Forward		
Lateral		
24. Back Abnormalities		
25. Skin		
26. Nervous: Organic		
Functional		
27. Anus		
28. Other Diseases		
29. Urinalysis: Sugar		
Alb.		
30. Chest X-ray		
IF APPLICANT IS A FEMALE:		
31. Are you now pregnant		
How far advanced		
32. Have you now or ever had any disease or tumor of the breast		
Uterus		
Ovaries		
33. Are your menstruations regular and healthy		

RATING

A B C D

REMARKS

SIGNED _____ M. D.

2. Urinalysis; Complete Blood Count; Sedimentation Rate; Electrocardiogram with or without exercise tolerance (at discretion of examiner); Blood sugar; large x-ray of chest.

It is understood that if further study is needed in order to come to sound conclusions that this can be arranged for with either the cooperating welfare fund or the companies using the service.

The costs of the examinations should be:

(1) A—$10.00; (2) B—$50.00.

Conferences Held

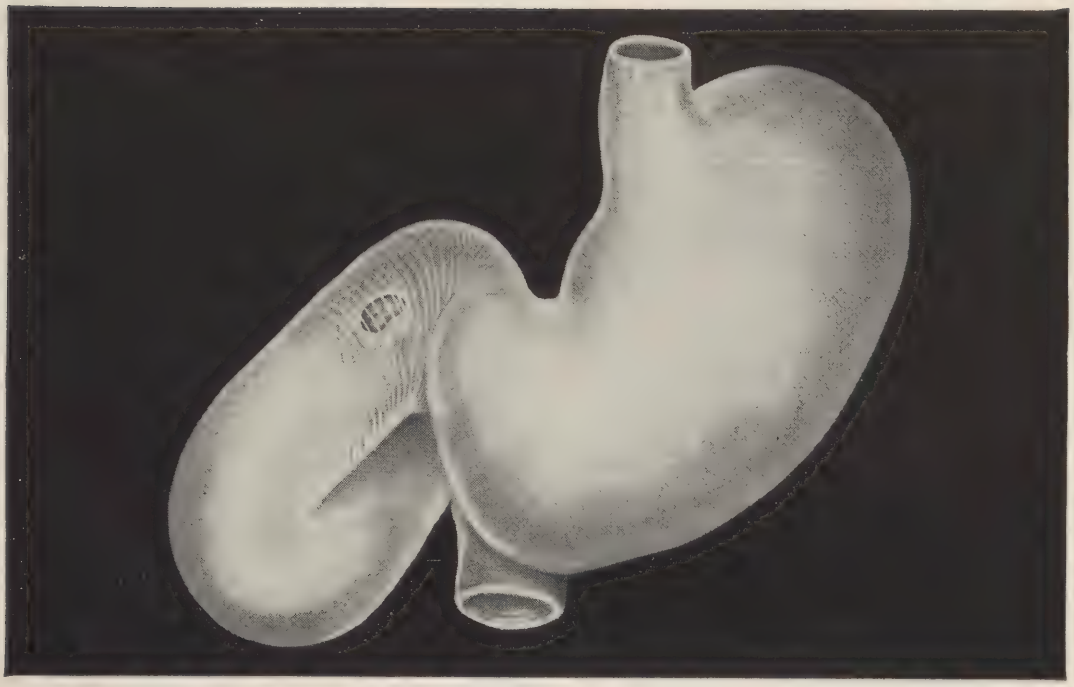
It is imperative that these two plans and charges be discussed and time is valuable. A committee of the Trumbull County Medical Society has been cooperative with us on this project and they accept in principle the above recommendations.

We have had several meetings with the Mahoning & Trumbull County Building Trades Welfare Fund Committee and they feel this is a new and vivid approach to what in the past has amounted to rebuffs. Therefore, I urge that we approve this at once as it is a monumental step forward in preserving the best physician-patient relationship.

This arrangement with the welfare fund members is a very good and practical plan for us as physicians and for members of the fund as our patients. The examination form as given, is quite easy to complete, but is very thorough. In the event that there is any reason for further studies these will be permitted to be requested by means of voucher and thus still preserve the best possible patient-physician relationship. It is my considered judgment that this plan will be approved by the Trumbull County Medical Society and I certainly feel it should meet with our full approval.

P. J. Mahar, M. D., Chairman; E. R. McNeal, M. D.; S. W. Ondash, M. D.; A. K. Phillips, M. D.; Asher Randell, M. D.; R. J. Scheetz, M. D.; E. A. Shorten, M. D.

CONFIRMED THERAPEUTIC UTILITY



Pro-Banthine® "proved almost invariably effective in the relief of ulcer pain,

*in depressing gastric secretory volume and in inhibiting gastrointestinal motility."**

"Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies."*

Among the many clinical indications for Pro-Banthine (brand of propantheline bromide), peptic ulcer is primary. During treatment, Pro-Banthine has been shown repeatedly to be a most valuable agent when used in conjunction with diet, antacids and essential psychotherapy.

Therapeutic utility and effectiveness of Pro-Banthine in the treatment of peptic ulcer are repeatedly referred to in the recent medical literature.

Pro-Banthine Dosage

The average adult oral dosage of Pro-Banthine is one tablet (15 mg.) with meals and two tablets at bedtime.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

Hospital Consent Forms . . .

This Vital Subject Discussed in Recent Report of the Accreditation Commission; Handling of Infections Also Covered in this Bulletin

CONSENT forms, handling of infections in hospitals and a progress report on the five-year work of the Commission were subjects discussed in Bulletin No. 17 (March, 1958) of the Joint Commission on Accreditation of Hospitals. Following are excerpts from the bulletin:

* * *

The question of medical professional liability was discussed at the Board of Commissioners' meeting and it was decided that hospitals should be advised that many consent forms presently in use are inadequate and should be re-evaluated. The Commissioners did not and will not endorse any specific form. They recommend that the hospital obtain local legal counsel in its preparation. In principle the form should be an informed consent which means that the signer knows what he is signing, knows what is to be done, and understands the risk involved to the patient. It should include such information as the following:

Name of the hospital in which the operation or procedure is to be performed, and date consent is signed.

Name of the patient on whom the operation or procedure is to be performed.

Statement of the nature of the operation or procedure to be performed.

Authorization for administration of anesthesia, if necessary.

Authorization to perform such additional operations or procedures as are considered necessary or desirable in the judgment of the surgeon or physician.

Consent to dispose of tissues or parts removed at operation.

Statement that the signer is aware of the contents of the form he is signing.

Signature of patient or person legally authorized to give consent on patient's behalf.

Signature of witness.

(Note: An excellent booklet on consent forms relating not only to hospital procedures but also medical procedures was prepared recently by the Law Department of the American Medical Association. A copy may be obtained by writing directly to the AMA.)

Infections in Hospitals

Articles on infections in hospitals have appeared recently in medical and hospital literature as well as in the lay press. This is a subject of concern to the Joint Commission on Accreditation of Hospitals, since accreditation implies that the hospital maintains a safe environment for patients. The surveyors of the Commission are instructed to check into the matter of infections in hospitals and to help hospitals in their efforts to educate hospital personnel on the cause, effect and elimination of infections. They also make certain that every hospital has instituted proper control methods towards the prevention of infections. Hospitals should be alert to the fact that there is a tendency to relax rigorous aseptic precautions in hospital housekeeping and to rely too much on new detergents, ultraviolet lights and antibiotics. There is still no better method of obtaining good sanitation and cleanliness in a hospital than the judicious use of soap and water, under vigilant care and supervision.

The Commission strongly suggests that hospitals implement the recommendations made by a special conference committee of the American Medical Association. In part, they recommend that:

Recommendations

1. There should be diligent research in hospitals into the causative organisms and their special properties which render them so infective and dangerous, and a search for immunologic and chemotherapeutic measures against them.

2. Every hospital establish a responsible officer or committee charged with the investigation and control of infections within the hospital, and institute procedures and practices designed to prevent infections. Membership on the committee should include medical staff, administration and nursing service personnel.

3. There is need also for community participation in these problems, for instance, by the County Medical Societies, local health departments, Hos-

See anybody here you know, Doctor?



I'm just too much

AMPLUS®
for sound obesity management
dextro-amphetamine plus vitamins and minerals

I'm too little

STIMAVITE®
stimulates appetite and growth
vitamins B_1, B_6, B_{12}, C and L-lysine

I'm simply two

OBRON®
a nutritional buildup for the OB patient

OBRON® HEMATINIC
when anemia complicates pregnancy

And I'm getting brittle

NEOBON®
5-factor geriatric formula
hormonal, hematinic and nutritional support

With my anemia, I'll never make it up that high

ROETINIC®
one capsule a day, for all treatable anemias

HEPTUNA® PLUS
when more than a hematinic is indicated

(Prescription information on request)

. . . solve their problems with a nutrition product from ROERIG

New York 17, New York
Division, Chas. Pfizer & Co., Inc.

pital Councils and Interhospital Committees on Infections.

Progress Report

During the five years the Joint Commission on Accreditation of Hospitals has been functioning, there has been a steady gain in the number of accredited hospitals. This is shown in Table 1. The 1952 figures indicate the number of hospitals accredited by the American College of Surgeons when the Commission came into existence.

TABLE 1.—*Number of Hospitals Accredited.*

	1952	1953	1954	1955	1956	1957
TOTAL	3265	3395	3513	3630	3770	3857
U. S. and Possessions	3085	3111	3219	3319	3141	3525
Canada	269	275	285	302	318	321
Foreign	8	9	9	9	11	11

During the five year period 1953-1957, the total number of hospitals which took part in the accreditation program was 4521. Of this number 3857 (85.4 per cent) are accredited and 664 (14.6 per cent) are not accredited. It is encouraging to note that the hospitals not accredited are working diligently to achieve accreditation and many have requested re-survey. Experience has shown that progress toward accreditation is accelerated after a survey and improvement in patient care has resulted. Even though a hospital does not achieve accreditation on the first visit, a survey is of considerable value.

Table 2 shows the number of surveys that have been done by the Commission.

TABLE 2.—*Number of Surveys Conducted.*

	TOTAL	1953	1954	1955	1956	1957
TOTAL	7155	1306	1385	1378	1421	1665
U. S. and Possessions	6494	1213	1233	1234	1299	1515
Canada	649	92	151	136	120	150
Foreign	12	1	1	8	2	

Of the total number of surveys done, 6390 (89.3 per cent) resulted in accreditation and 765 (10.7 per cent) in no accreditation. The proportion of those resulting in no accreditation has dropped from 11 per cent in 1953 to 8.2 per cent in 1957. The Commission finds this trend encouraging. It supports the theory that a large number of hospitals which have been surveyed and not accredited have the potential to become accredited.

It is estimated that there are 7,000 hospitals in the United States and Canada eligible for accreditation. Of this number 55.1 per cent are accredited.

Dr. Claude S. Perry, Columbus, was guest speaker at a meeting of the Isthmian Canal Zone Medical Association, recently. His topic was: "Ophthalmological Complications of Diabetes."

Ninth District and Portsmouth G. P.'s Sponsor Program on May 8

The Ninth District of the Ohio State Medical Association and the Portsmouth Chapter of the Academy of General Practice are jointly sponsoring a program on Thursday, May 8, in Portsmouth, it was announced by Dr. William J. Hartlage, program director for the Portsmouth G. P.'s, and Dr. C. L. Pitcher, Ninth District Councilor.

The program will be at the Elks' City Club, with registration open at 12:30 p. m. and the first program feature at 1:15.

The program to be conducted by a team from Ohio State University College of Medicine, has been announced as follows:

"Uses and Abuses of Cortisone," Dr. Robert J. Goldberg.

"The Acute Abdomen in Children," Dr. Robert J. Izant.

"What's New in Hormone Therapy," Dr. Geo. J. Hamwi.

"The Sterile Female," Dr. Charles W. Pavey.

Panel Discussion.

Social hour and banquet.

There will be 4½ hours credit in Category 1 for general practitioners.

Ohio State Surgical Association Forms Discussion Groups

The Ohio State Surgical Association has set up a plan to help county medical societies in presenting programs for physicians.

Under the direction of Dr. Byron G. Shaffer, Toledo, a past-president, a committee is forming four- or five-man discussion panels in each of the Association's eight areas.

Upon invitation the panel groups will travel to small communities for appearances before local medical societies and at the expense of the Ohio State Surgical Association. Topics to be discussed will include diagnostic as well as surgical procedures.

Panel moderators named to date are Drs. Warren G. Harding II, Columbus; Paul A. Mielcarek, Cleveland; George N. Bates, Toledo; C. C. Burton, Dayton; Daniel E. Early, Cincinnati; A. C. Ormond, Zanesville; Edward V. Arbaugh, Martins Ferry; and Philip W. Smith, Marion.

County Medical Societies interested in using the speakers should write to the association office, 526 East Dunedin Rd., Columbus.



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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

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Hill-Burton Program . . .

Hospital Building and Improvement in Ohio Has Been Given Extraordinary Impetus Through This Program Now In Its Second Decade of Administration

OHIO'S Hospital Building Program under the provisions of the Federal Hill-Burton Act has entered its second decade.

Where the program has been and where it is going are set forth in a recent report assembled by Dr. Margaret DuBois, chief of the Division of Hospital Facilities, Ohio Department of Health. This article is based on that report.

Since the start of the Hill-Burton Hospital Building Program in Ohio, commitments have been made for 103 projects, totalling 8,099 beds. The total cost of these 103 projects is $153,771,110.00 of which the Federal Government contributed $36,-003,963. A breakdown of these figures into categories is shown in the accompanying statistical table.

The report in the following language points out that the program has amounted to more than just the building of the additional beds cited:

Has Stimulated Planning

"The program has accomplished much more than this, however. The value of state-wide planning has been recognized. Groups interested in constructing health facilities—regardless of application or eligibility for federal grants—now tend to consult the Ohio Department of Health to determine what, if anything, they should plan. Consultation is frequently requested in regard to planning and equipping nonparticipating projects. Potential donors to capital fund drives and voters on bond issues are interested in learning how the proposed project fits into the State plan.

"There is much wider general interest in facilities for the care of old people and patients with chronic diseases, and in the need for rehabilitation of the handicapped. Communities as a whole are becoming much more aware of the importance of recognizing and filling their health needs. General standards for design, construction and operating programs have been improved. These developments, most certainly stimulated by the "Hill-Burton" Act and its subsequent amendments, are in themselves indicative of the success of this program."

Basic Requirements

Approval of Federal grants to aid in hospital construction is contingent on meeting certain basic requirements of the Federal act and regulations. Summarized, these are as follows:

1. Demonstration of local need sufficient to result in high priority
2. Provision of a community-wide service on a non-profit basis
3. The ability to provide sufficient matching funds to finance the project
4. Compliance with specific structural standards, including existing structures to be remodeled
5. Certain specific requirements for specific categories of facilities

Basic Policies

To facilitate administration of the program, the Ohio Department of Health has adopted some basic policies, as outlined:

1. Federal grants may not exceed 33 1/3 per cent of the eligible cost of the project.
2. Applications will not be considered for
   (a) Hospitals providing a total of less than 50 beds **except**
   (1) Inpatient facilities for rehabilitation centers (chronic disease hospital category)
   (2) Replacements of existing hazardous facilities, and
   (3) Hospitals providing 25 - 50 beds where so indicated by special geographic location, community population and the assurance of an adequate program for patient care and long range plans for expansion to at least 50 beds.
   (b) Nursing homes providing a total of less than 25 beds **except**
   (1) Nursing home units of general hospitals
   (2) Nursing home units of homes for the aged, and
   (3) Nursing homes providing 10-25 beds where so indicated by special geographic location, community population and the assurance of an adequate program for patient care and long range plans for expansion to at least 25 beds.

More on Policies

3. When a project has been approved for a grant, requests to increase the grant for increased

Summary of Hill-Burton Hospital Projects in Ohio to Date And Amount of Federal Funds Committed

Category of Project	*Total Cost*	*Federal Grants*	*Number of Projects*	*Beds*
General Hospitals	$120,341,375	$29,162,101	70	6,500
*Mental Hospitals	9,158,170	1,063,927	4	235
Tuberculosis Hospitals	5,009,725	922,760	5	410
Chronic Disease Hospitals	9,950,435	2,024,895	2	790
Nursing Homes	2,073,155	683,213	3	164
D and T Centers	1,175,895	391,965	3	xxx
Rehabilitation Facilities	2,850,000	839,558	2	xxx
Public Health Centers	2,451,695	686,026	4	xxx
Schools of Nursing	760,660	229,518	1	xxx
Totals	$153,771,110	$36,003,963	103	8,099

*Psychiatric Units of General Hospitals

scope of the project will not be considered. The project sponsor may submit a new application for the increase as a new project.

4. Applications for grants from Part "C" funds (general, tuberculosis and mental hospitals, psychiatric units of general hospitals and public health centers) must be submitted prior to May 15 each year for funds available the following July 1.

5. Applicants must be ready for bids within one year from the date of approval by the Ohio Department of Health. Applications should not be formally submitted until there is reasonable assurance of adequate local matching funds.

6. Applications for public health center grants will be considered only from qualified local or district health departments.

7. Applications for rehabilitation facility and chronic disease hospital grants will be given priority on the basis of multiple disability services and research and teaching programs.

8. Applications for nursing home grants will be considered only when such homes are operated by an acceptable hospital, or have a formal affiliation with an acceptable hospital for assurance of good patient care and for immediate or future training of professional and nonprofessional personnel.

9. Restudy of hospital service area boundaries will be undertaken on request provided that data sufficient to warrant such restudy are submitted with the request.

Changes in Format

Some changes in the format of the plan have been initiated this year. In part, this is a simplification; in part it is devised to present a clearer picture of the situation in each of the 11 regions of the state. The report states: "It is generally conceded that the time has come to analyze over-all health needs in a community rather than 'How many general hospital beds are needed?' The general hospital is becoming the health center of the community or area; as such, it should assume leadership in studying these broader health needs. Community surveys on this basis are being encouraged, including careful review of current patient loads within existing general hospitals."

Ohio State Coroners' Association Elects Officers for Year

Dr. Lyman A. Adair, of Wooster, Wayne County Coroner, was elected president of the Ohio State Coroners' Association, at the organization's annual seminar and business meeting in Toledo. He succeeds Dr. William J. Pittinger, of Summit County.

Other officers elected are: Dr. W. R. Larrick, (D. O.), Cambridge, vice-president; Dr. Charles H. Edel, Norwalk, treasurer, and Dr. Samuel R. Gerber, Cleveland, re-elected secretary.

College Health Association Honors Dr. Chenoweth

Dr. Laurence B. Chenoweth, for many years head of the University of Cincinnati student health service, was honored with the merit award for his several decades of contributions to the college health field at the thirty-third annual meeting of the Ohio College Health Association at Capital University, Columbus.

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Ohio State Surgical Association Program Scheduled June 4-5 In Cincinnati

The Ohio State Surgical Association has announced its fifth annual meeting to be held in Cincinnati with special events scheduled on Wednesday, June 4, and a scientific program on Thursday, June 5.

Wednesday is designated as fun day with golf arrangements at the Kenwood Country Club. Special events for the ladies also have been arranged.

The program and dinner dance on Thursday will be at the Netherland Hilton Hotel.

The Scientific Program

The scientific program has been announced as follows:

Morning Session

John H. Lazzari, M.D., Presiding

9:00 a.m. **The Place of Angioplastic Procedures in the Management of Peripheral Occlusive Arterial Disease.**
D. Emerick Szilagyi, M.D., Detroit, Michigan.

9:30 p.m. **Management of Acute Head Injuries.**
Robert L. McLaurin, M.D., Cincinnati.

10:00 a.m. **Surgery of the Patient with Jaundice**—Panel Discussion.
Moderator:
Max M. Zinninger, M.D., Cincinnati.
Collaborators:
Charles B. Puestow, M.D., Chicago, Illinois.
Leon Schiff, M.D., Cincinnati.
Henry K. Ransom, M.D., Ann Arbor, Mich.

11:30 a.m. **Carcinoma of the Cervix—Present Concepts of Early Diagnosis and Therapy.**
Richard W. TeLinde, Baltimore, Md.

12:00 Noon **Pitfalls in the Treatment of Ankle Injuries.**
Harrison L. McLaughlin, M.D., New York, N.Y.

12:30 p.m. Luncheon—Netherland Hilton Hotel

(Surgical Ass'n. Program—Cont'd.)

Afternoon Session

John H. Lazzari, M.D., Presiding

2:00 p.m. **Resuscitation of the Heart.**
Claude S. Beck, M.D., Cleveland.

2:30 p.m. **Present Trends in the Management of Cancer of the Colon and Rectum.**
Henry K. Ransom, M.D., Ann Arbor, Mich.

3:00 p.m. **The Modern Surgical Treatment for Peptic Ulcer.**
Ralph F. Bowers, M.D., Memphis, Tennessee.

3:30 p.m. **Current Problems of Antibiotic Therapy in Surgery.**
William A. Altemeier, M.D., Cincinnati.

4:00 p.m. **Chronic Pancreatitis with Special Reference to Caudal Pancreaticojejunostomy.**
Charles B. Puestow, M.D., Chicago, Illinois.

4:45 p.m. Business Meeting — For Members Only.

Columbus Academy and Pharmacists To Hold Joint Program June 5

The Columbus Academy of Medicine will hold a joint meeting with the Central Ohio Academy of Pharmacy at the Neil House in Columbus on Thursday, June 5. The program will begin at 5 p. m. and speakers from pharmaceutical houses will speak. A short business meeting will be followed by a social hour and dinner.

An outstanding after-dinner speaker has been invited to present the discussion of the evening on pharmacology and medicine.

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Forand Bill . . .

Letter Alerting and Warning Physicians Against Dangers of H. R. 9467 Sent to All Physicians by AMA President; Questions Answered in Folder

SEVERAL weeks ago a communication was sent to all physicians by Dr. David B. Allman, president of the American Medical Association, relative to the Forand Bill—H. R. 9467—now before the Ways and Means Committee of the House of Representatives, U. S. Congress.

The letter was accompanied by a folder which contained detailed information about the Forand Bill.

Following is the text, in part, of Dr. Allman's letter and the content of the pamphlet which was in question-answer style.

Dr. Allman's Letter

"A bill now in Congress would place the health care of the aged and other OASI claimants under government supervision.

"The Forand bill—H. R. 9467—would provide government hospital and medical care for about 13 million social security claimants by amending the Social Security Act. The AFL-CIO sponsored this bill and has given it top legislative priority.

"The Forand bill is not in the public interest. There are several basic reasons why it is bad legislation for all Americans. These are:

"1. It would bring the aged under government controlled and supervised health care. The government would set and enforce standards of health care under bureaucratic control, limiting the choice of hospitals and physicians.

"2. It would eventually destroy private health insurance and the Blue Shield-Blue Cross plans.

"3. It would introduce into the economy of the country, on a permanent basis, wage, fee and price fixing by government fiat.

"4. It is national compulsory health insurance for a segment of our population. Once established, this concept would be extended to all social security claimants. Ultimately America would have nationalized hospitals and medical care for everyone.

"5. It is an attempt to solve a complicated health problem by political means rather than through established medical resources. Making the aged wards of the government with health care handouts is not the proper way to solve the problem.

"6. It would mean higher taxes and less take-home pay for all wage earners for the benefit of a minority.

"7. It could bankrupt the entire social security program and jeopardize the basic retirement incomes of millions of Americans.

"Every physician must be prepared to oppose this bill vigorously and be ready to make his views known to the Congress should that become necessary. . . .

"Meanwhile, some of the most important and respected organizations in the health field are preparing a program which will lead toward solution of the problems of health care for the aged. . . .

Questions and Answers on Bill

Q. What is the Forand Bill?

A. The Forand bill, H. R. 9467, is an AFL-CIO sponsored amendment to the present Social Security Act. The bill proposes to provide government hospital and surgical care for approximately 13 million eligible social security claimants, principally persons over 65. The bill was introduced in the House in August 1957 by Rep. Aime J. Forand (D., Rhode Island). It was referred to the House Ways and Means Committee of which Forand is the third ranking member. The committee is expected to begin hearings in May.

Q. What would the Forand Bill do in the field of health care?

A. Bring the aged and other Old-Age Survivors Insurance claimants under government-supervised health care. The government would make contractual agreements to reimburse hospitals, nursing homes, physicians and dentists for specified services rendered to the 13 million (1958) social security claimants (expected to be as many as 22 million by 1975). Payments would be made directly to hospitals, physicians and nursing homes. No payments would be made to individual claimants.

Q. What would the health care proposals cost all workers?

A. There is no way of accurately predicting the cost. It could prove so costly that it would jeopardize the retirement security of millions of Americans who depend on social security for their basic retirement needs. For the first time last year the social security system received less income than it paid out. Taxes to finance the present program are already scheduled to reach 8½ per cent of

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payroll up to $4,200 in coming years. The Forand bill provides for raising the social security tax base from the first $4,200 of income to the first $6,000. The tax rate would also be increased ½ of 1 per cent for both employers and employees and ¾ of 1 per cent for self-employed persons. This increase, in addition to those already provided by the social security law, would mean that a self-employed person could be paying $427.50 in social security taxes by 1975.

Q. Would this raise in the social security tax cover the cost of the program?

A. Possibly at its inception. However, other countries with similar socialistic health programs have found that their costs were several times larger than the original estimates. It is most likely that the Forand bill program would eventually cost much more than two billion dollars per year and that the taxes would have to be raised accordingly.

Q. What are the basic faults of the Forand bill in the field of health care?

A. The Forand bill proposes a political solution to a health problem. It is a health care bill developed by non-medical people (chiefly the AFL-CIO).

Q. Would the Forand Bill adversely affect health care for the rest of the population?

A. Over-utilization of hospitals by social security claimants would limit the number of beds available for the acutely ill of all ages in the community. Provisions for extensive free hospitalization would create a needless and dangerous crowding of hospital space. In many countries where similar legislation is in effect, there has been a staggering increase in use of hospital facilities by those over 65. (In Saskatchewan, Canada, for example, the average person over 65 occupies a hospital bed 7.2 days a year; in the United States the average person over 65 occupies a hospital bed 2.5 days a year.)

Q. Could all doctors, hospitals and nursing homes participate?

A. No. Only those that enter into contracts with the government. Furthermore, except in an emergency, surgery could be performed only by a surgeon certified by the American Board of Surgery or one who is a member of the American College of Surgeons. Elective surgery is not included. Care would not be authorized in a mental or tuberculosis hospital. Nursing homes would (1) have to be operated in connection with a hospital or (2) operated under the general direction of a licensed doctor or surgeon.

Q. Who would determine fees for doctors and charges for hospitals and nursing homes?

A. The Federal Department of Health, Education and Welfare would make the final determination.

Q. Who would administer this program and set standards of care?

A. The program would be administered by the Secretary of Health, Education and Welfare. The government would set and enforce standards of health care under bureaucratic control.

Q. What hospital and nursing home services would be provided by the Forand bill?

A. The bill provides a combined total of 120 days free hospital and nursing home care but with a maximum of 60 days hospitalization. However, before a person can receive nursing home care he must be transferred there from a hospital for further treatment of the same illness.

Q. Are any other services provided by the Forand bill?

A. Oral surgery would be provided, but only to those persons who were hospital bed patients. Oral surgery is not defined.

Q. What effect would the Forand bill have on voluntary health insurance?

A. The health insurance industry has proved its ability to handle the extensive insurance needs of our growing population. Because of its experience and success in other fields, it is reasonable to allow it time to solve this additional problem—medical coverage for our citizens in the 65-and-over group. Approximately 50 per cent in this age bracket has some coverage now, as compared to only 20 per cent in 1950. Passage of the bill would give voluntary health insurance a set-back from which it would never recover. This bill would do irreparable harm to the one method through which our older citizens can take care of their health needs on a free-choice basis maintaining full independence. Under the Forand bill the aged would become, in effect, wards of a bureaucratic system.

Q. How do the uninsurable receive health care?

A. The 3.5 million or so, 65 or over, who are uninsurable because of inadequate income, assets, or other means of support generally receive medical care through welfare programs. Aside from aid granted by many private, fraternal, and religious organizations, over three billion dollars in federal and state aid is given annually to those in the four categorical aid programs (aid to the blind, handi-

capped, dependent children, aged) for medical and other expenses.

Q. How good are the statistics on the health problems of the aged?

A. AMA has studied the available statistics. They have been found to be neither conclusive nor complete. The greatest need right now is for a comprehensive study of the health problems of the aged, rather than for drastic remedies for a situation about which so little is known.

Q. Could the age limit for Forand health care be held at 65?

A. Probably not. Supporters of the bill have indicated that they would like to see government-regulated health care made available to younger persons, perhaps first starting at age 60, then 55, and so on, eventually bringing everyone under a government dictated health program. Ultimately the practice of medicine in America would be totally socialized, which could result in an inferior grade of health care.

AMA Supports Legislation for Handling Aviation Medicine

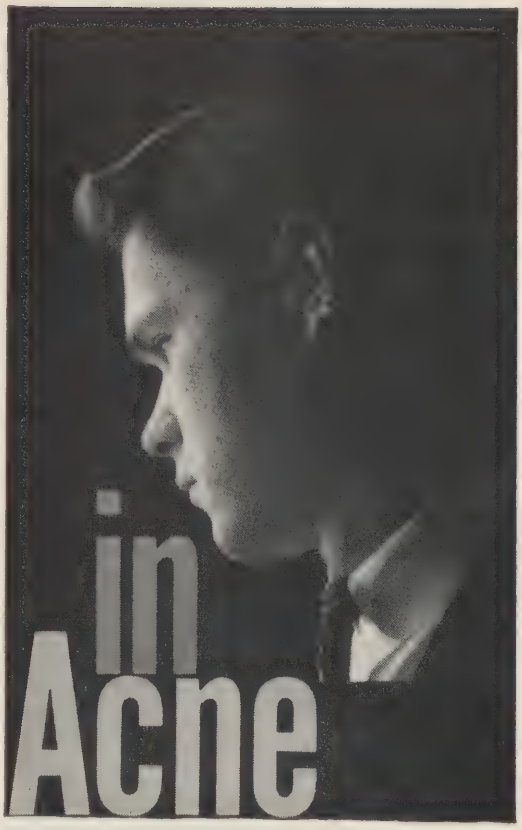
The American Medical Association is actively supporting legislation pending before Congress which would establish a separate medical office within the Civil Aeronautics Administration.

In a letter to Sen. Warren G. Magnuson, chairman of the Committee on Interstate and Foreign Commerce, Dr. F. J. L. Blasingame, AMA general manager, said, "The American Medical Association is seriously concerned with the present state of civil aviation insofar as medical matters are concerned. Increasing air traffic and the jet age, accompanied by increased physical demand on pilots, require a substantial revision in the present method of handling many aspects of aviation medicine."

Specifically, the AMA is urging passage of Senate Bill 1045 which is before Senator Magnuson's committee.

The letter also said that physical standards for and medical evaluation of fliers "must be carried out by physicians experienced in aviation medicine, and medical determination should be conducted by physicians—who have the necessary professional qualifications and experience."

Provisions of the bill include: Transfer of the rule-making authority for medical standards from the Civil Aeronautics Board to the Civil Aeronautics Administration (unlike the CAA, the Civil Aeronautics Board does not have qualified medical personnel); Creation of the "Office of Civil Air Surgeon" directly responsible to the Civil Aeronautics administrator; Establishment of a Civil Aeronautics Medical Research Laboratory.



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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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In Memoriam . . .

Samuel R. Bame, M. D., Carey; Eclectic Medical College, Cincinnati, 1911; aged 73; died March 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Bame had been a practicing physician in Carey since 1917 in which year he moved there from Alvada. A veteran of World War I, he was a member of the American Legion. Surviving are his widow, a son, a daughter, two brothers and a sister.

Susan Willard Brown, M. D., Cincinnati; Rush Medical College, 1922; aged 66; died March 20; former member of the Ohio State Medical Association. Dr. Brown began her career in medicine as a medical missionary in China for the Methodist Church, but for health reasons returned to this country. She was a resident physician at Dunham Hospital until 1938 when she went into private practice. Two sisters survive.

Louis F. Bucher, M. D., Dayton; Rush Medical College, 1900; aged 80; died March 9; former member of the Ohio State Medical Association; recipient of the OSMA 50-Year Award. A native of Germany, Dr. Bucher came to this country as a child with his family which settled in Dayton. In addition to his private practice, he served as Dayton school doctor from 1910 to 1921 and was instrumental in establishing the city's first school health program. In 1943 he was called out of retirement to become examining physician for the local procurement program. He held several posts with the Fraternal Order of Eagles and as national child health chairman helped organize five well-baby clinics in the Dayton area. He also was a member of the Elks Lodge, and a past exalted ruler of that organization. Surviving are a sister and two brothers.

Harry L. Burdsall, M. D., Hamilton; Medical College of Ohio, Cincinnati, 1905; aged 79; died March 25; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Burdsall practiced a total of 53 years, all of it in and around the Lindenwald community of Hamilton. He held at various times all the offices in the Butler County Medical Society and served on a number of local committees. During World War I, Dr. Burdsall served in the Army Medical Corps. Among organizations to which he belonged, was the Odd Fellows. His widow and a daughter survive.

John W. Cronin, M. D., Washington, D. C.; University of Cincinnati College of Medicine, 1933; aged 52; died March 26. A career man with the U. S. Public Health Service, Dr. Cronin advanced to become Assistant Surgeon General of the service and chief of the Bureau of Medical Services. Surviving are his widow, a son and a daughter.

Howard V. Dutrow, M. D., Dayton and Oakwood City; University of Maryland School of Medicine and College of Physicians and Surgeons, 1904; aged 77; died March 19; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Oto-Laryngology; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology; past-president of the Montgomery County Medical Society; recipient of the OSMA 50-Year Award. Dr. Dutrow's practice in the Dayton area dates from 1913. For 30 months during World War II he served with the Medical Corps of the Army Air Force. He was a member of several Masonic bodies, the Dayton City Club, the Dayton Country Club and the Elks Lodge. Surviving are his widow, a daughter, three sisters and a brother.

Walter Alfred Haldy, M. D., formerly of Cleveland; Western Reserve University School of Medicine, 1902; aged 78; died March 22; former member of the Ohio State Medical Association. A native of Cleveland, Dr. Haldy practiced there for about 40 years, retiring in 1943. Survivors include his widow and a brother.

Harry G. Harris, M. D., Dayton; New York Medical College, 1912; aged 80; died March 25. Dr. Harris was associated with the membership department of the Central YMCA in Dayton until his retirement in 1953. Many years ago he practiced in Jamestown, N. Y. He is survived by his widow and a son.

Clarence E. Hufford, M. D., Toledo; Western Reserve University School of Medicine, 1920; aged 65; died March 25; member of the Ohio State Medical Association, the American Medical Association, the American Roentgen Ray Society, Radiological Society of North America, American College of Radiology, American Radium Society; Fellow of the American College of Physicians; diplomate of the American Board of Radiology; past-president of the Academy of Medicine of Toledo and Lucas County; member and former chairman of the OSMA Committee on Cancer; alternate delegate of the OSMA to the American Medical Association. Dr. Hufford's practice of

medicine in the Toledo area dates to 1921. His interest in radiology and cancer brought him national recognition in both fields. Despite his many interests in these fields, he found time to devote to other organization work. He was a past-president of the Northwestern Ohio Medical Association, was active in the Toledo Public Health Association and was a trustee of the Child and Family Agency. He was also a member of the Toledo Area Chamber of Commerce, the Toledo Club and the Presbyterian Church. He was a trustee of the Ohio Division of the American Cancer Society and served many other cancer organizations. Surviving are his widow; his son-in-law and daughter, Dr. and Mrs. Robert Willard; and his mother.

Louis A. Levison, M. D., Toledo; University of Michigan Medical School, 1903; aged 77; died March 10; member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; member of the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. Levison began his practice in Toledo after doing graduate work abroad. In addition to his professional associations, he was active in several Masonic bodies, the Elks Lodge, the Collingwood Temple and B'nai B'rith. Surviving are his widow, a son and a daughter.

George W. Lewis, M. D., Pierpont; Jefferson Medical College of Philadelphia, 1895; aged 87; died March 25. Dr. Lewis opened an office at Pierpont the year after his graduation from medical school and practiced there for 62 years. A veteran of World War I, he was a former member of the American Legion and a 50-Year member of the Masonic Lodge. Four sons survive.

Margaret O'Neal, M. D., Zanesville; Western Reserve University School of Medicine, 1930; aged 54; died March 28; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics; member of the OSMA Committee on School Health. A native of Zanesville, Dr. O'Neal began practice there in 1934. In 1942 she became Zanesville's city physician and in 1949 Muskingum County health commissioner, later also serving Guernsey County in the same capacity. Surviving are her mother and a brother.

John M. Sayler, M. D., Dayton; Starling Medical College, Columbus, 1903; aged 79; died March 18. Dr. Sayler had been living in Dayton following retirement as physician for the Balti-

new -non-ionic

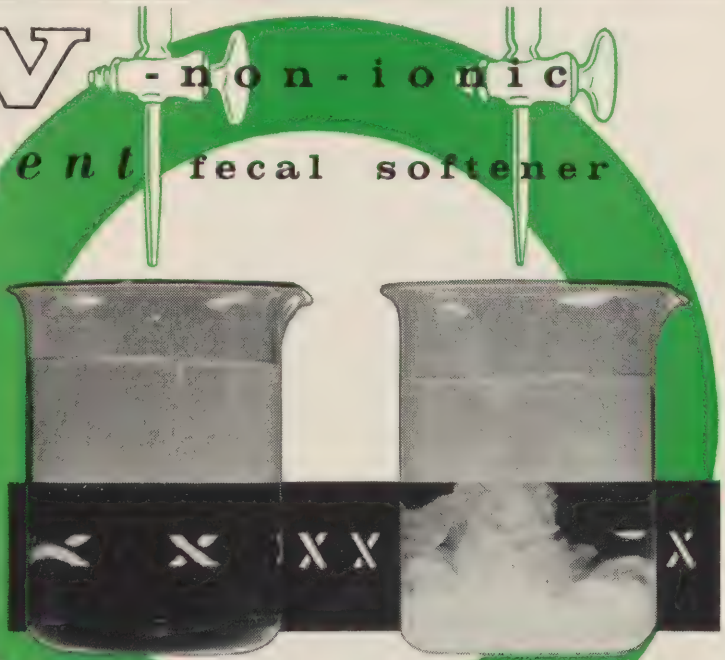
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These beakers contain identical gastric juices. The cloudy precipitation in beaker B is produced when an ordinary wetting agent ionizes and unites with these juices. The active ingredient in Magnocyl is not precipitated by chemical combinations in the digestive process—retains its wetting effect under all conditions.

Since there is no precipitation, you can't see Magnocyl at work in beaker A. It's the "natural" answer to a problem as old as man. Magnocyl can be safely prescribed to maintain softness of stool for infants, children and adults of all ages.

Each Magnocyl capsule contains polymer of ethylene oxide and propylene oxide—250 mg.



Beaker A—Magnocyl

Beaker B—Ordinary wetting agent

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more and Ohio Railroad, first in Cincinnati and later in Cleveland. From 1903 to 1917 he practiced in Christiansburg. He was a member of several Masonic bodies. Surviving are his widow, a daughter and a son.

Jacob Homer Schaeffer, M. D., Cridersville; Medical College of Ohio, Cincinnati, 1891; aged 93; died March 19; former member of the Ohio State Medical Association. Dr. Schaeffer practiced continuously in Cridersville from 1896 until his retirement five years ago. For many years he was surgeon for the B & O Railroad. He was a member of the Methodist Church and the Odd Fellows. Survivors include his widow, a daughter and a brother.

James F. Wilson, M. D., Washington Court House; College of Physicians and Surgeons of Baltimore, 1909; aged 76; died March 4; former member of Ohio State Medical Association. Dr. Wilson began his practice in Stark County and moved to Good Hope, in Fayette County in 1921. Six years later he moved to Washington C. H. as Fayette County health commissioner. From 1942 to 1945 he was in Rogers City, Mich., as health commissioner, but returned in the latter year to Washington C. H. He was a member of the Methodist Church and the Masonic Lodge. Survivors include his widow, a daughter and two sons.

Bunts Institute in Cleveland To Present Pathology Course

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, in conjunction with the Cleveland Society of Pathologists is offering a postgraduate course on Clinical Pathology, Thursday and Friday, May 15 and 16.

The course will be held on the fourth floor of the North Clinic Building located at Euclid Avenue and East 93rd Street, Cleveland.

Registration opens at 8:30 a. m. on Thursday with the first program feature at 9:00 a. m. Registration is $20, with $5 requested for registration in advance.

This course has been coordinated with and immediately precedes the spring meeting of the Ohio Society of Pathologists which will be held Saturday, May 17.

Speakers

(Positions given are in the Cleveland Clinic Foundation unless otherwise indicated.)

Harriet P. Dustan, M. D., Division of Research.

Willard R. Faulkner, Ph. D., Department of Clinical Pathology.

Adrian Hainline, Jr., Ph. D., Department of Clinical Pathology.

(Bunts Institute Program—Cont'd)

Mary Harmon, M. D., Department of Pediatrics.

John R. Haserick, M. D., Department of Dermatology.

William A. Hawk, M. D., Department of Pathology.

James S. Hewlett, M. D., Department of Hematology.

Victor S. Hirsch, M. D., Visiting Pathologist, Sunny Acres Hospital, Cleveland.

George C. Hoffman, M. D., Department of Clinical Pathology.

John W. King, M. D., Department of Clinical Pathology.

Charles L. Leedham, M. D., Director of Education, Frank E. Bunts Institute.

Lena Lewis, Ph. D., Division of Research.

S. P. Masouredis, M. D., Ph. D., Associate Professor of Pathology, University of Pittsburgh, School of Medicine and Associate Director, Central Blood Bank, Pittsburgh, Pa.

Lawrence J. McCormack, M. D., Department of Pathology.

Robert O. Oseasohn, M. D., Department of Medicine and Preventive Medicine, Western Reserve University, School of Medicine and University Hospitals, Cleveland.

Arthur L. Scherbel, M. D., Department of Rheumatic Disease.

Donald A. Senhauser, M. D., Department of Clinical Pathology.

Leonard T. Skeggs, Ph. D., Biochemist, Crile Veterans' Administration Hospital, Cleveland.

Irving Sunshine, Ph. D., Toxicologist, Cuyahoga County Coroner's Office and Assistant Professor of Toxicology, Western Reserve University.

Scott N. Swisher, M. D., Associate Professor of Medicine, University of Rochester, School of Medicine and Dentistry, Rochester, N. Y.

Devina C. Tweed, Ph. D., Department of Clinical Pathology.

Carl E. Wasmuth, M. D., Department of Anesthesiology.

Thursday Morning, May 15

Dr. Hainline, Presiding

8:30 Registration

9:00 Introductory Remarks and Welcome, Dr. Leedham

9:15 **Tri^{131} Uptake in Thyroid Disease,** Dr. King

9:35 **Blood Volume Determinations,** Dr. Wasmuth

(Bunts Institute Program—Cont'd)

9:55 **Medical Aspects of Biophysics,** Dr. Masouredis
10:50 Coffee Break
11:05 **Abnormal Hemoglobins,** Dr. Lewis
11:25 **Certain Aspects of Fungus Disease,** Dr. McCormack
11:45 **Determination of Barbiturate Intoxication,** Dr. Sunshine
12:05 Question and Answer Period
12:30 Lunch—Courtesy of the Bunts Institute.

Thursday Afternoon

Dr. King, Presiding

2:00 **Hemophilia,** Dr. Harmon
2:20 **Parahemophilia,** Dr. Hewlett
2:40 **The Anti-Human Globulin (Coombs) Test,** Dr. Hoffman
3:00 **Clinical and Experimental Transfusion Reactions,** Dr. Swisher
3:50 Coffee Break
4:10 **ABO Sensitizations,** Dr. Senhauser
4:30 **Laboratory Technics in Lupus Erythematosus,** Dr. Haserick
4:50 Question and Answer Period
7:00 Hospitality Hour—Wade Park Manor (Wives Invited)

Friday Morning, May 16

Dr. McCormack, Presiding

9:00 **The Addis Count,** Dr. Dustan
9:20 **Blood pH Measurement,** Dr. Faulkner
9:40 **Protein Bound Iodine Determination,** Dr. Tweed
10:00 **The Use of Isotopes in Clinical Laboratory Diagnosis,** Dr. Masouredis
10:50 Coffee Break
11:05 **Latex Fixation Tests in Rheumatic Diseases,** Dr. Scherbel
11:25 **Technics of Urine Culture,** Dr. King
11:45 **Asian Influenza,** Dr. Oseasohn
12:05 Question and Answer Period
12:30 Lunch—Courtesy of the Bunts Institute

Friday Afternoon

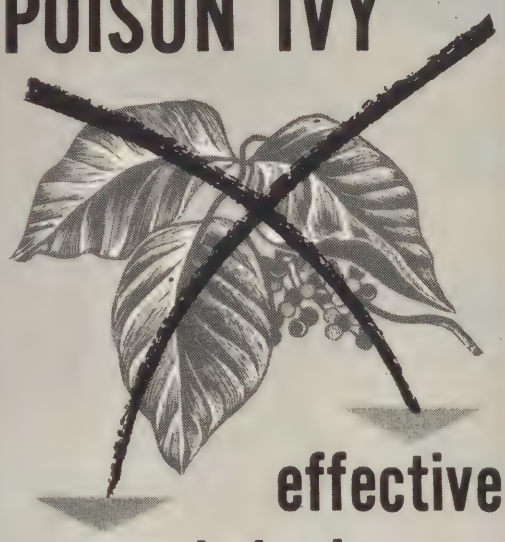
Dr. King, Presiding

2:00 **Laboratory Diagnosis of Tuberculosis,** Dr. Hirsch
2:20 **Serum Iron Determination,** Dr. Hainline
2:40 **Acquired Hemolytic Anemia with Special Reference to Red Cell Physiology,** Dr. Swisher
3:30 Coffee Break
3:45 **Blood Platelets,** Dr. Hawk
4:05 **Automation in the Laboratory,** Dr. Skeggs
4:25 Questions, Answers, and Critique

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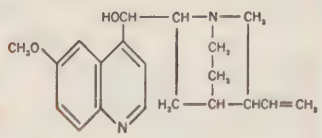
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"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

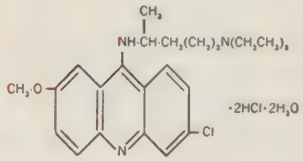
"... Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

"... the least toxic of its class ..."[3]

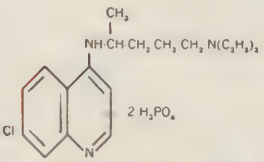
QUININE



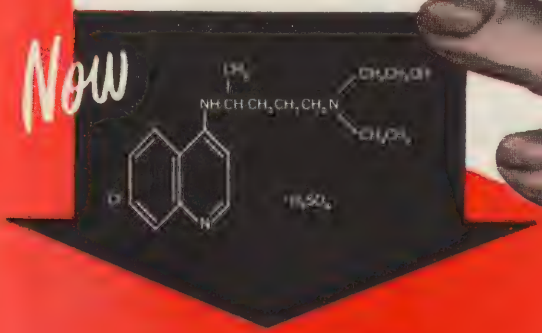
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SUPPLIED: Tablets of 200 mg., bottles of 100.

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REFERENCES

1. Scherbel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
2. Schoch, A.G., and Alexander, L.J.: The Schoch section, *Bull. U. S. Dermatologists* 5:35, Nov., 1956.
3. Cornbleet, Theodore: *Arch. Dermat.* 73:579, June 1956.

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ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDING DECEMBER 31, 1957, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand, January 1, 1957:

Cash in Huntington National Bank:		
Accumulated unexpended income of prior years	$ 9,273.18	
1957 Exhibit payments in 1956	6,403.50	
		$ 15,676.68
Cash in Ohio National Bank (1957 Dues)		36,300.00
U. S. Treasury and Savings Bonds		90,000.00
Total Cash and Bonds		$141,976.68

RECEIPTS

Interest on U. S. Treasury and Savings Bonds	$ 2,327.00	
Interest on Buckeye Fed. S. & L. Savings Account	200.43	
1957 Membership dues collected in 1957	179,500.00	
1958 Membership dues collected in 1957	48,985.00	
1957 Exhibit space collected in 1957	14,251.50	
1958 Exhibit space collected in 1957	5,462.50	
Banquet tickets sold	2,362.50	
Payment for collection of American Medical Association dues	1,854.26	
Total Receipts		$254,943.19
Total To Be Accounted for		**$396,919.87**

DISBURSEMENTS

The Ohio State Medical Journal	$ 35,000.00	
Executive Secretary, salary	16,500.00	
Executive Secretary, expense	1,032.61	
Administrative Assistant, salary	8,000.00	
Administrative Assistant, expense	1,682.92	
Stenographic and Clerical salaries	31,529.45	
President, expense	972.52	
President-Elect, expense	378.05	
Council, expense	3,388.16	
American Medical Association Delegates	3,503.46	
Dept. of Public Relations:		
Director, salary	14,000.00	
Director, expense	1,420.30	
Assistant Director, salary	9,500.00	
Assistant Director, expense	2,187.41	
Exhibits and newspaper publicity	54.53	
Literature	1,835.97	
Postage	1,953.45	
Supplies	527.64	
Miscellaneous Activities	2,364.44	
Standing Committees:		
Public Relations and Economics	443.21	
Scientific Work	531.10	
Judicial and Professional Relations	451.57	
Education	25.00	
Special Committees:		
Auditing and Appropriations	940.00	
Chronic Illness	217.58	
Government Medical Services	139.67	
Hospital Relations	516.63	
Industrial Health	174.77	
Maternal Health	1,483.42	
Military Advisory Chairman, salary	2,250.00	
Military Advisory, expense	154.50	
Miscellaneous	433.92	
Rural Health	5,238.49	
School Health	2,242.39	
Veterans' Affairs	103.49	
Annual Meeting	19,560.85	
Conference County Society Presidents-Secretaries	1,321.67	
Emergency and Equipment Fund	3,385.80	
Employees Retirement Fund	4,392.93	
Insurance and Bonding	3,409.10	
Legal Expense	10,230.16	
Library	204.73	
Postage	2,000.00	
Professional Relations Activities	7,598.84	
Rent and Utilities	8,951.81	
Rural Medical Scholarships	2,000.00	
Stationery and Supplies	3,249.96	
Telephone and Telegraph	2,466.11	
Refunds: Banquet tickets	45.00	
Dues	60.00	
Total Disbursements		$220,053.61

Cash on Deposit; Bonds; Savings Account on Hand, December 31, 1957:

Huntington National Bank:		
Accumulated unexpended income for 1957	$ 22,218.33	
1958 Exhibit payments collected in 1957	5,462.50	
Total deposit	$ 27,680.83	
Ohio National Bank (1958 Dues)	48,985.00	
U. S. Treasury and Savings Bonds	90,000.00	
Savings Account, Buckeye Fed. S. & L. Co.	10,200.43	
Total Cash, Bonds, and Savings Account		$176,866.26
Total Accounted For		**$396,919.87**

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets:		
Cash in Ohio National Bank		$ 1,815.64
Petty Cash		30.00
Total Cash		$ 1,845.65
Accounts Receivable: Advertising, net	$ 15,355.22	
Postage deposit	160.00	15,515.22
Total current assets		$17,360.86
Property Assets:		
Furniture and equipment, depreciated value		16,147.90
Total Assets		**$ 33,508.76**

LIABILITIES AND NET WORTH

Net Worth, December 31, 1956	$ 30,612.03	
Net income for year ended December 31, 1957	2,896.73	
Total Net Worth, December 31, 1957		$33,508.76

STATEMENT OF PROFIT AND LOSS

Income:		
Advertising, gross		$ 83,190.03
Less: Commission on advertising	$ 8,849.34	
Cash discount on advertising	729.70	9,579.04
Advertising income, net		$ 73,610.99
Ohio State Medical Association appropriation		35,000.00
Subscriptions and sales		1,147.40
Ohio State Medical Association appropriation for equipment		2,750.22
Repayment of postage and supplies		112.57
Total net income		$112,621.18
Expenses:		
Salaries	$ 14,760.00	
Journal printing	86,828.72	
Journal postage	1,407.15	
Stationery, printing, and supplies	3,882.78	
Illustrations and engravings	594.25	
Travel expense	118.00	
Miscellaneous postage	244.45	
Miscellaneous expense	150.00	
Depreciation	1,633.20	
Bad debts (unpaid advertising)	105.90	
Total expenditures		$109,724.45
Net Income for the year		**$ 2,896.73**

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

ALLEN

Dr. James R. Jarvis was guest speaker at the March 18 meeting of the Academy of Medicine of Lima and Allen County. His discussion was on legislative matters pertaining to the medical profession and the public.

HAMILTON

Dr. Irvine H. Page, director of research at the Cleveland Clinic, was the guest speaker for the March 18 meeting of the Academy of Medicine of Cincinnati. His subject was "Fat, Cholesterol and Arteriosclerosis."

For the April 1 meeting a symposium on "Open Heart Surgery," was held as a joint meeting with the Heart Council. Guest speakers were Dr. Donald B. Effler, chief of the Department of Thoracic Surgery, Cleveland Clinic, and Dr. F. Mason Sones, Jr., director of the Heart Catheterization Laboratory, Cleveland Clinic.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

A University of Iowa professor addressed the Clark County Medical Society at the group's March 17 general meeting in Hotel Shawnee, Springfield.

The Speaker was Dr. Raymond G. Bunge, professor of urology, University of Iowa College of Medicine, Iowa City, Ia.

Dr. Bunge's topic was "What Is Sex After All?" The talk was based on research the doctor had done in differentiating sexes by microscopic examinations of skin specimens.

Program chairman for the Clark County Medical Society is Dr. E. H. Winterhoff. He is assisted by Doctors George Smith, co-chairman; Harold Fishbain, G. R. Horton, George Parker and John Elliott.—Tom Duross.

DARKE

"Use of Hormones in Obstetrics and Gynecology," was the subject discussed by Dr. John M. Roll, Dayton, at the March 18 dinner meeting of the Darke County Medical Society in Greenville.

GREENE

Dr. Clarence G. McPherson, Xenia, who began the practice of medicine in Greene County in 1908, was honored for his half century of service at the 10th anniversary dinner of the auxiliary to the Greene County Medical Society, attended by 57 persons March 19 at the Antioch Union at Yellow Springs.

Dr. McPherson was graduated from Ohio State University medical school in 1908 and began his medical practice that same year. He has continued to practice in Xenia except for a period during World War I when he served in the Medical corps.

The 50-year medical veteran also formerly was a member of the Xenia City Commission and also has served in the past as secretary, vice-president and president of the Greene County Medical Society. For many years, he also served as delegate from Greene County to the Ohio State Medical Assembly.

Dr. Dean Dooley, Dayton, district counselor of the Ohio State Medical Association, presented Dr. McPherson with a certificate and 50-year pin and congratulated him on his long period of service.

Dr. Benjamin Lee, Xenia, president of the Greene County Medical Society, gave the response to the presentation.—*Xenia Gazette.*

MIAMI

The Miami County Medical Society was host to the Shelby County Medical Society for a luncheon meeting and program on April 3. The meeting was at the Piqua Country Club. Guest speaker was Dr. Drew J. Arnold, assistant professor of surgery, Ohio State University, whose subject was, "Regional Ileitis."

MONTGOMERY

The General Practice Section of the Montgomery County Medical Society and the local group of the Academy of General Practice met for a program on March 19 and luncheon at the Van Cleve Hotel, Dayton. Speaker was Capt. L. J. Filer, of the research unit at Wright-Patterson Air Force Base.

The Dayton Medical Foundation, established by the Medical Society in 1951 for research and education purposes, has renewed its grant of $3,000 for operation of the central homograft bank in Dayton.

Dr. A. V. Black, President of the Montgomery County Medical Society, announced the appointment of Kenneth C. Evans as associate executive secretary of the Society. Mr. Evans received education in business administration at Ohio State University and served as an Army captain in the European theater during World War II. He worked in expense control for several years at the

Frigidaire plant, and lately has been business manager of the Westminster Presbyterian Church in Dayton. Mr. Evans is married and the father of two daughters.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

LOGAN

Dr. Sidney J. Glueck, Springfield, was principal speaker on March 7 before the Logan County Medical Society. The dinner meeting was held in the Mary Rutan Hospital in Bellefontaine. Dr. Glueck spoke on "Eye Diseases and Eye Surgery."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

SANDUSKY

At the March meeting of the Sandusky County Medical Society the question of social security for doctors was discussed for the second time. This time the results were unanimously against physicians being included under the social security program.

At the March meeting, 50-Year Pins were presented to Dr. C. M. Cooper, of Bellevue, and Dr. E. A. Baker, Clyde. Presentations were made by Dr. Paul F. Orr, Perrysburg, Councilor of the Fourth District.—Paul E. Burson, M. D., Secy.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

LAKE

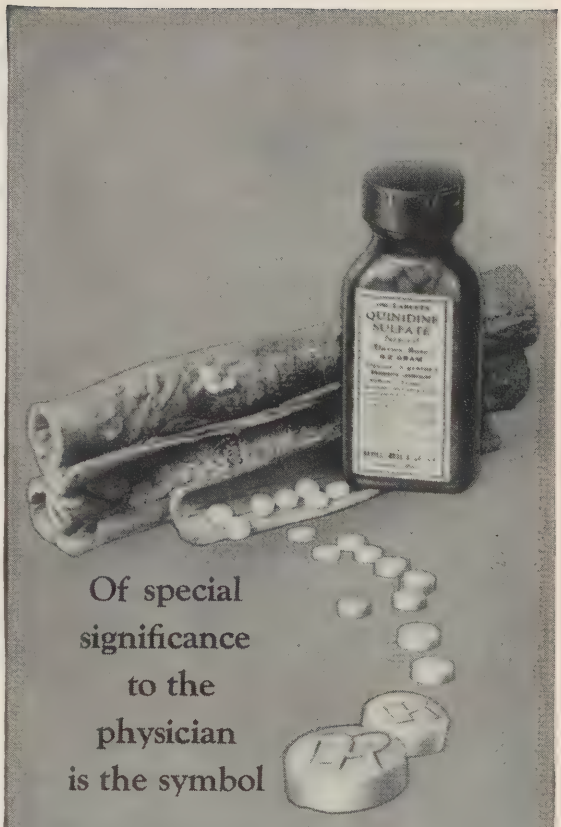
The Lake County Medical Society held its March 12 meeting at Hellriegel's Inn, with Dr. Robert A. Irvin presiding. Forty members and two guests attended.

An announcement of the Poison Information Center, established by the Cleveland Academy of Medicine, was made. Lake County physicians are urged to avail themselves of this community service.

Dr. George Petznick, Councilor for the Fifth District, attended and spoke about a number of changes in medicine, and urged physicians to be aware of these problems. He recommended a pamphlet "What Everyone Should Know About Doctors" for waiting-room literature.

Dr. Myron Perlich, Assistant Professor of Medicine at Western Reserve University and head of the TB Division at Cleveland City Hospital, spoke on "The Significance of Positive Tuberculin and Positive Patch Tests in the Younger Age Groups."

A film "Time and Two Women" put out by



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Q-7

the American Cancer Society was shown, and approved for showing to the lay public by the Medical Society. — Marjorie S. McLaren, Executive Secretary.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Dr. Leo H. Criep, of Pittsburgh, was guest speaker at a dinner meeting of the Columbiana County Medical Society on March 12. Dr. Criep is medical lecturer of immunology and chief of the allergy clinic at the University of Pittsburgh.

TRUMBULL

More than 100 doctors and lawyers attended a combined dinner meeting of the Trumbull County Bar Association and the Trumbull County Medical Society at the Trumbull Country Club March 19.

They were treated to a discussion on medical-legal problems by two prominent Cleveland men, Oliver Schroeder, director of the law medicine institute of Western Reserve University, and Dr. Lester Adlson, assistant coroner and pathologist of Cuyahoga County.

The program was entitled "Observation, Inference, Presumption, the Medical-Legal Aspects."—*Niles Times.*

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society with the Auxiliary met at the Belmont Hills Country Club on March 20 for dinner and a program. Speaker was Dr. William H. Havener, Ohio State University Department of Ophthalmology, who discussed, "Red Eye as Seen in Everyday Practice."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy held its quarterly dinner meeting and program at the Neil House in Columbus on April 9. The program consisted of the showing of the film, "The Medical Witness," a panel discussion on the various aspects of medical testimony, a short business meeting, a social period, dinner, and a talk by the guest speaker. The subject, "Law, Medicine and the Truth," was discussed by Oliver C. Schroeder, Jr., Cleveland attorney, director of the Law-Medicine Center and professor in the School of Law, Western Reserve University.

ROSS

Dr. William Molnar, of the Radiology Department, Ohio State University, presented a program to members of the Ross County Academy of Medicine on March 6. His topic was "The Specific Methods of X-Ray Diagnosis of the Portal Circulatory System." Dr. Lewis Coppel, president of the Society, presided.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The March meeting of the Lorain County Medical Society was held at the Oberlin Inn Tuesday, March 11. The doctors honored their wives as guests of the Society. Dr. H. T. Pease, Councilor of the 11th District, and his wife were also guests of the Society. In all, 121 members and guests attended.

A brief review of the beginnings of the Lorain County Medical Auxiliary was presented by the president, Dr. B. V. Myers. Mrs. S. J. Birkbeck was given an ovation as first president of this fine organization.

Drs. Albert A. Fisk, Konstantis Jakobson, Tamas A. Lanczy and Antonio Trzeciak were elected to Active Membership. An executive secretary, Mrs. H. A. Zealley of Elyria has been hired.

The Annual Lorain County Symposium to be held May 7, at the Oberlin Inn, was announced. The speakers for the Symposium to come from Western Reserve School of Medicine.

The entertainment of the evening was provided by Mr. Hank Bothe of Elyria, a color motion picture with authentic African sounds — entitled "African Safari"—professionally done escapist fare for the busy M. D. who may dream of hunting big game in Tanganyika.—L. C. Meredith, M. D., Secretary-Treasurer.

RICHLAND

On February 27 the Richland County Medical Society held its meeting in the Westinghouse Electric Corporation plant, Mansfield. Following a welcome and a short talk about the facilities by the works manager, Mr. William Heald, supervisor of the Westinghouse Insurance Plan for Employees, spoke concerning the plan and how cooperation between the plant and the doctors can reduce the work involved for each and improve service to the patient. A question and answer period followed during which several problems were clarified. Seventy-six members of the Society were present for the affair and all present took a plant tour following the meeting in the auditorium.

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New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since February 1st, 1958. The list shows the county in which they are affiliated, city in which they are practicing, or temporary address in cases where physicians are taking postgraduate work.

Belmont County
Richard E. Lewis, St. Clairsville

Clark County
Richard H. Tapogna, Springfield

Clermont County
Robert R. Freund, Loveland

Cuyahoga County
Borys G. Andriewsky, Cleveland
Kenneth C. Archibald, Cleveland
Verners Berzins, Cleveland
Byron M. Bloor, Cleveland
Richard C. Britton, Cleveland
Kenneth H. Burdick, Cleveland
Marvin G. Brook, Cleveland
David J. Chesler, Maple Heights
Sophie Chmielnicki, Cleveland
Leslie S. Dean, II, Rocky River
Bernard V. Dryer, Cleveland
Edwin H. Eigner, Cleveland
George G. Graham, Cleveland
Keith R. Irish, Cleveland
John J. Johnson, Cleveland
Matthew N. Levy, Cleveland
Joseph F. Lydon, Cleveland
Rachel B. McDougal, Cleveland
Clifford D. Molzahn, Cleveland
Irene Sym Plaskach, Cleveland
David J. Samon, Cleveland
Otto P. Schumacher, Cleveland
Richard H. Seibert, Cleveland
Richard T. Silvers, Cleveland

Darke County
Alvan E. Thuma, New Madison

Franklin County
Winslow J. Bashe, Jr., Columbus
Herbert G. Birck, Columbus
Robert M. Blizzard, Columbus
Norman S. Brandes, Columbus
Bertram D. Dinman, Columbus
Alexander Horava, Columbus
Richard T. Messick, Columbus
Richard E. O'Brien, Columbus
Robert L. Reinhart, Columbus
John K. Scott, Columbus
Christodoulos B. Theodotou, Columbus
Robert E. Visintine, Columbus
Wilburn H. Weddington, Columbus

Gallia County
Edwin F. Aune, Gallipolis

Geauga County
David A. Corey, Chardon

Hamilton County
W. Donald Heuer, Cincinnati
Nathan Polasky, Cincinnati
James Poon, Indianapolis, Ind.
Erich Spiro, Cincinnati
Eduardo Z. Schmidt, Cincinnati

Hancock County
Samuel F. Lowery, McComb

Jefferson County
Raymond B. Cagnina, Brilliant

Knox County
Lee F. Kramer, Mt. Vernon

Licking County
Andrew M. Gulliford, Newark

Lorain County
John H. Adrain, Los Angeles, Calif.
Peter Volodkevich, Elyria

Lucas County
Franz Berlacher, Toledo
Doris A. Berlin, Toledo
Jerrold L. Berry, Toledo
Edward Conrad, Toledo
Bernard J. Cullen, Toledo
Simon Dorfman, Toledo
Richard F. Gehring, Toledo
Thomas W. Holmes, Jr., Toledo
Stanislaus Jaudzems, Toledo
John J. Ockuly, Toledo
Peter A. Overstreet, Toledo
Barbara B. Stein, Toledo

Madison County
Julio A. Ayulo, Mt. Sterling

Mahoning County
Vitalij Holonko, Youngstown
David D. Krongold, Youngstown
Frederick H. Sassler, Youngstown
William H. Taake, Youngstown
James Medley, Youngstown
John J. Turner, Youngstown

Montgomery County
Ian H. Brown, Dayton
Wallace E. Johnson, Dayton
Benjamin Schuster, Dayton
Gordon E. Smith, Dayton

Richland County
Barbara A. Reed, Mansfield
George W. Loesch, Mansfield

Sandusky County
William M. Hindman, Fremont

(Continued in Next Column)

Medical-Hospital Benefits Paid in Ohio Total $168-Million in 1957

Benefit payments by insurance companies to the people of Ohio who are covered by health insurance policies reached a new high during 1957, the health Insurance Institute reported today.

In the period from January 1 through December 31, 1957, said the Institute, over $168.5-million was paid out to help cover the cost of hospital and doctor bills, and to replace income lost through sickness or disability. This represents a 17.5 per cent gain over the 1956 figure of $143.4-million, and is based upon reports from insurance companies doing business in the state.

The rise in benefit payments in Ohio was also reflected in the figures for the nation as a whole, the Institute further noted. Persons protected against the expenses of hospital and medical care and treatment received a total of $2.5-billion in benefits from their insurance company policies in 1957, up 16.1 per cent over the previous year's high of $2.1-billion. By the end of the year, an estimated 70-million persons were covered by health cost policies bought from insurance companies, more than all other types of voluntary health plans combined.

Several Changes Have Been Announced Among Local Health Officers

It was announced recently that Dr. Charles Roy Steingrube has been named to succeed Dr. J. P. Owens as Hamilton County health commissioner.

Dr. Hilbert Mark, director of local health administration for the Minnesota Department of Health, has been named Toledo health commissioner.

In the Trumbull County Health Department, Dr. David R. Mathie succeeded Dr. R. L. Thomas.

Dr. O. C. Jackson became Monroe County health commissioner recently.

Acting health commissioner for the Butler County Department is Dr. James A. Schaal. A full-time health officer is sought.

The Washington County Health Department has joined with the City of Marietta to employ a full-time health officer. He is Dr. Richard L. Wenzel, formerly with the Columbus Health Department.

(New OSMA Members—Cont'd)

Seneca County
Olierd C. Garlo, Tiffin

Stark County
Peter D. Peters, Minerva
Anne W. Robinson, Canton

Summit County
Cloyd F. Wharton, Jr., Akron
Donald S. Nelson, Akron

Wayne County
Jerry N. Bosnak, Wooster
Robert E. Schulz, Wooster

Wood County
John H. Marsh, Bowling Green

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Women, of course, like "Premarin," too, because it quickly relieves their symptoms and gives them a "sense of well-being."

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Activities of Woman's Auxiliary . . .

Woman's Auxiliary to AMA

The thirty-fifth annual meeting of the Woman's Auxiliary to the American Medical Association will be held in San Francisco, California, June 23 to 27, 1958, with headquarters at the Hotel Fairmont.

A cordial invitation is extended to all members of the Woman's Auxiliary, their guests and the guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general meetings of the Auxiliary. Tickets for the various social functions will be available at the registration desk. The Hospitality Room will be in the Green and Empire Rooms on the first floor.

Registration will start at noon on Sunday, June 22.

Monday, June 23—Round table discussions on all facets of Auxiliary activities and programs will be held in the morning and early afternoon. Later in the afternoon the annual tea in honor of the National President and President-Elect will be held, Mark Hopkins Hotel, Peacock Court.

Tuesday, June 24—General meeting and luncheon in honor of the national past-presidents. In the afternoon will be State Projects Reports with the National Committee Chairmen as moderators.

Wednesday, June 25—General meeting and luncheon in honor of the national president and president-elect. Dr. David B. Allman, president of the American Medical Association, will be the guest speaker. Round table discussions will be continued immediately following luncheon.

Thursday, June 26—General meeting until noon. Meeting of the Board of Directors in the afternoon, followed by informal discussion of committee programs for 1958-59 with the national committee chairmen.

Friday, June 27—Postconvention conference of state presidents, presidents-elect, national committee chairmen, and members.

To allow more free time, the annual dinner will be eliminated this year.

On Thursday afternoon a tour of outstanding homes with beautiful views of San Francisco Bay have been chosen for this House Tour.

The January 4, 1958, issue of the *AMA Journal* carried a list of the hotels with prices and a reservation form. Please use it when requesting reservations. The Housing Bureau has been instructed to give this form preference in the allocation of rooms.

BUTLER COUNTY

The Butler County Bar Association Auxiliary members were guests at the March 25 meeting of the Butler County Medical Auxiliary luncheon at the Hamilton City Club.

Mrs. Andrew Chevey, Bar Auxiliary president, introduced her officers. Mrs. Joseph Peil, Medical Auxiliary program chairman, introduced Mrs. Lynn Blevins and Mrs. Arthur Hoffman, both of Anderson, Indiana, who presented the program a skit entitled "I'm Sure, My Love." Mrs. Hoffman highlighted the skit by vocal selections between the acts.

Those present from Middletown were Mrs. Peter Ammertoys, Mrs. Rodney Caudill, Mrs. Ross Hill, Mrs. Peil, Mrs. John Sawyer, Mrs. Calvin Skinner, Mrs. Gilbert Wagoner, Mrs. Paul Woodward, Jr., Mrs. Louis Gaker, Mrs. Robert Tennant and Mrs. Clifford Fering.

ERIE COUNTY

The Woman's Auxiliary to the Erie County Medical Society created a St. Patrick's Day theme for their monthly meeting held at the Business Women's Club.

Following the luncheon, the guest speaker, Mrs. James Rhiel, a Port Clinton doctor's wife and former art teacher at Ohio State University, gave a talk entitled "Art as a Personal Experience."

A short business meeting followed in which Mrs. Sigismund Veechey repeated the Auxiliary pledge and was welcomed as a new member.

FAIRFIELD COUNTY

Seventeen members of the Woman's Auxiliary to the Fairfield County Medical Society enjoyed a luncheon in the home of Mrs. Galon Rodabaugh on March 10. Assistant hostesses were: Mrs. F. A. Dowdy, Mrs. C. H. Hamilton, Mrs. H. M. Amstutz and Mrs. L. H. Urling.

The President, Mrs. George LeSar, conducted the business meeting. She announced that $75 had been donated to the American Medical Education Foundation by the local auxiliary.

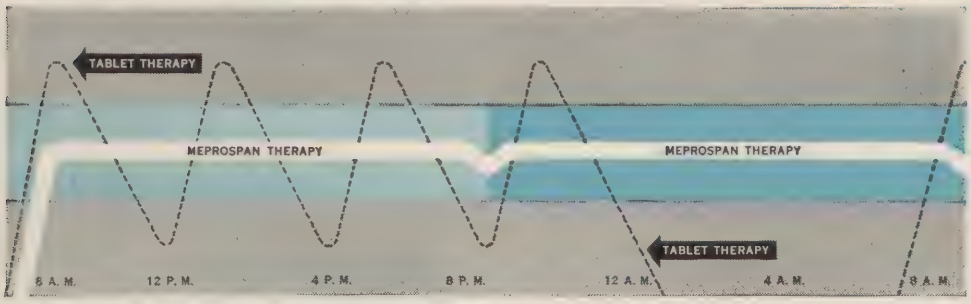
Mrs. Rodabaugh, chairman of Nurse Recruitment, reported that her committee had consulted with the hospital staff, and plans have been made to give the senior members of the Lancaster High School Future Nurses' Club an opportunity to spend a night and a day at the Nurses' Home.

Mrs. C. R. Reed read the report from the nominating committee as follows: Mrs. G. F. Jones, president; Mrs. C. F. Clark, president-elect; Mrs. James Beesley, vice-president; Mrs. W. D. Nusbaum, secretary; and Mrs. C. H. Hamilton, treasurer.

The public was urged to attend the free movies at the Palace Theatre to view two films on cancer,

New... meprobamate prolonged release capsules

Evenly sustain relaxation of mind and muscle 'round the clock



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"The Other City" and "Time and Two Women." A question and answer period followed the showing of the films.

HAMILTON COUNTY

A four-year college scholarship leading to the degree of Bachelor of Science in Nursing has been provided by the Woman's Auxiliary to the Hamilton County Medical Society from its educational and philanthropic fund. Mrs. Robert H. Kotte, is chairman of the committee which worked out the details and requirements of the grant.

A series of four television shows depicting the opportunities and requirements of fourteen specific careers in health was presented in 12 telecasts from April 3 to May 2 by Station WCET-TV. The Auxiliary worked with the Committee on Careers in Health of the Cincinnati Hospital Council in producing the shows. In the cast of the first show, which dramatized opportunities in nursing, were high school girls from the Future Nurse Clubs which the Auxiliary sponsors in 11 Greater Cincinnati high schools. Mrs. Robert R. Pierce and Mrs. Edgar S. Lotspeich were the chairmen of this project.

The Auxiliary Choral Group, under the chairmanship of Mrs. Robert E. Drone, presented a varied program of songs in a television performance on April 8.

MAHONING COUNTY

More than 135 young women who plan to make nursing their careers learned more of that profession at the annual tea given March 11 at Stambaugh Nurses' Home at St. Elizabeth Hospital by the Woman's Auxiliary to the Mahoning County Medical Society. Invitations went out to junior and senior students of county and city schools who are scholastically qualified and interested in nursing. Mrs. John A. Renner, nursing school and recruitment chairman representing St. Elizabeth Hospital; Mrs. Lawrence Weller, who holds the same position at the Youngstown Hospital Association; Mrs. C. E. Pichette and Mrs. Frank Gelbman attended the tea table.

Speaker for the day was Miss Mary Code, director of nursing at St. Elizabeth whose topic was "Nursing as a Profession." The program was also highlighted by a tour of the hospital and school of nursing conducted by student nurses. Mrs. Cary S. Peabody presided at the auxiliary's business meeting which followed the tea.

RICHLAND COUNTY

Members of the Woman's Auxiliary to the Richland County Medical Society entertained their husbands at a dinner party on March 13 at the Sky Club. Sixty couples were present.





A St. Patrick's Day theme was used for the party, which was preceded by a cocktail hour. Special entertainment was provided by an orchestra comprised of a group of physicians. A "roaring 20's" dance routine was presented.

Mrs. L. D. Bonar was general chairman in charge of arrangements.

ROSS COUNTY

Mrs. H. M. Crumley reported on the success of Health Career Club at Chillicothe High School at the dinner meeting of the Woman's Auxiliary to the Ross County Medical Society held at the Lynne House.

She told the group that Career Club members toured Chillicothe Hospital recently and are planning to have a speaker from the Armed Forces Nursing Corps. They also are hoping to hear a talk by a nurse who has worked in a disaster area. A Red Cross film "Beyond the Call of Duty" was shown at the club's meeting on March 13.

The meeting was conducted by Mrs. Robert Swank who reported on the success of the Stork Club and noted that the group will meet twice a year instead of four times a year as in the past.

Other reports were given by Mrs. David McKell, exceptional child committee and Mrs. Crumley, nominating committee.

Mrs. Swank conducted the meeting of Hospital Guild 1 following the auxiliary session.

STARK COUNTY

The Woman's Auxiliary to the Stark County Medical Society met for a luncheon on March 19 in the Vogue Room of the Belden Hotel.

The program was a style show, with fashions by Polsky's. Highlight of the show, narrated by Miss Celia Marks, was "Surprise Jane," a model whose ensemble was auctioned for the American Medical Education Fund.

Mrs. Richard G. Spitzer presided at the business session which followed the luncheon. The membership voted to supplement the amount in the treasury for the American Medical Education Foundation to bring the total donated by Stark County to $1000.00.

Mrs. Cleon Couch was general chairman, assisted by Mrs. James Kilduff.

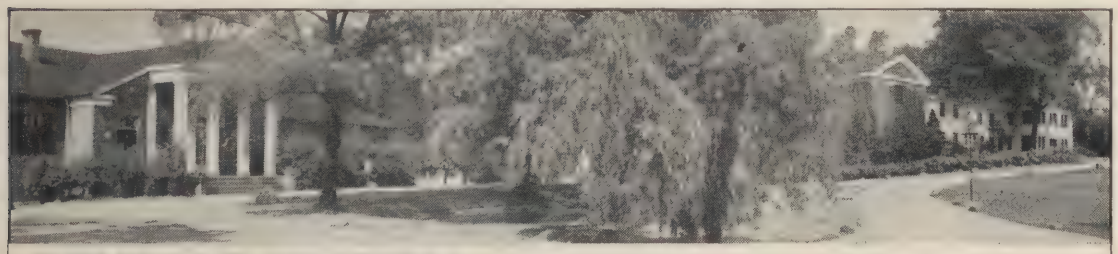
SUMMIT COUNTY

The Woman's Auxiliary to the Summit County Medical Society did not have a meeting in March due to the Eleventh Annual Health Days, held March 7-8-10th in the Auditorium of O'Neil's Department Store during the store hours. Chairman of the committee was Mrs. J. W. Parks. The theme this year was "Good Health a Community Endeavor." Forty-eight Health and Welfare Agencies participated. The Akron Chamber of Commerce's exhibit was on Safety. The Mansfield State Patrol showed slides and talked on Auto Fatalities. An interested group was comprised of the children in High School driving classes. Mr. Oldham, of the National Safety Council, looked over the show. The Summit County Medical Society exhibit "Life Begins" was repeated this year by popular request. Since 360 letters were sent to schools many students were required to visit this exhibit. There were 1578 free chest X-Ray's, 590 dental X-Ray's and 950 hearing tests given by the Summit County Association of Speech and Hearing Therapists.

Summit received excellent radio coverage with two programs, and *The Akron Beacon Journal* gave good newspaper coverage. Through these efforts approximately 8000 people attended the 1958 Health Days.

TRUMBULL COUNTY

A coffee klatch marked the March meeting of the Auxiliary to the Trumbull County Medical Society which was held at the Trumbull Memorial Hospital Auditorium. A short business meeting



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MEMBER: *American Hospital Association — Central Neuropsychiatric Hospital Association*
National Association of Private Psychiatric Hospitals
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was conducted by the president, Mrs. Clyde Muter who then introduced the guest speaker, Mr. Charles Crause, the Aetna representative of the Crause Insurance Agency of Warren. "Are Women Drivers?" was the theme of the program during which Mr. Crause used the Aetna Drivaquiz and re-actometer machines to rate the driving skill of his audience. A question and answer period was then held during which Mr. Crause answered inquiries about insurance coverage.

Several husbands of the members and resident hospital doctors also joined the group for the driving tests. Mrs. A. A. Guiducci and Mrs. L. A. Loria acted as co-hostesses for the meeting.

Telling the Story of Ohio's Services to the Blind

Three films dealing with blindness are being developed by Services for the Blind, Ohio Department of Public Welfare. The films, financed jointly by the Department of Welfare, Standard Oil of Ohio, and the Department of Health, Education and Welfare, are receiving national attention according to Mrs. R. L. Ireland, director of the Department of Welfare. Federal rehabilitation authorities feel that distribution of movies through television and other channels will serve as a demonstration project in bringing much needed knowledge to the problems of blindness to the citizens of Ohio.

The films, now in production under supervision of Cinecraft Productions, Inc. of Cleveland, follow scripts prepared by Storycraft, Inc. of which Frank Siedel, originator of **The Ohio Story**, is president.

"**Case Closed**" tells the overall story of services to blind people. The second film, "**The Taxpayers**" tells about the program of vocational rehabilitation for blind persons. It explains how a blinded person with appropriate help returns to the role of taxpayer indicating that rehabilitation services are a wise investment of state and federal funds.

A voluntary contribution by Standard Oil of Ohio made possible the production of the third movie, "**Save Your Sight.**" This film documents eye diseases and accidents, contains much information on conservation of vision, and the importance of early detection, and stresses the need for early referral for medical care.

Shooting of the films are taking place in various Ohio locations. In many instances, professional actors and narrators are being used, while in others, supervisors, field workers, home teachers, ophthalmologists and blind individuals play themselves. The films will be in full color and sound. A tentative date for the premier showing in Columbus is June 18th.

Cook County Graduate School of Medicine

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of the
UNITED STATES SECTION OF THE INTERNATIONAL COLLEGE OF SURGEONS
Presented in Cooperation With
COOK COUNTY GRADUATE SCHOOL OF MEDICINE

July 7-19, 1958—October 13-25, 1958

The United States Section of the International College of Surgeons will again offer its Annual Postgraduate Course, in cooperation with the Cook County Graduate School of Medicine. It will be a two-week intensive review course in General Surgery presented at the Graduate School, and in the wards and operating rooms of Cook County Hospital. Because the course has been oversubscribed in previous years, it will be offered twice in 1958.

The program will be offered under the supervision of the Hospital's Surgical Staff. It will include illustrated lectures, motion pictures, anatomy demonstrations, operative clinics and practice surgery by the participants on anesthetized dogs. Consideration will be given not only to surgical technic, surgical complications and management of the surgical patient, but also to an intensive review of the basic sciences in relation to clinical surgery. In addition to twenty hours of surgical anatomy on the cadaver, the program will include lectures and demonstrations on various aspects of general surgery.

The course will consist of 78 hours of instruction, and participants will be eligible for formal (Category I) credit from the American Academy of General Practice.

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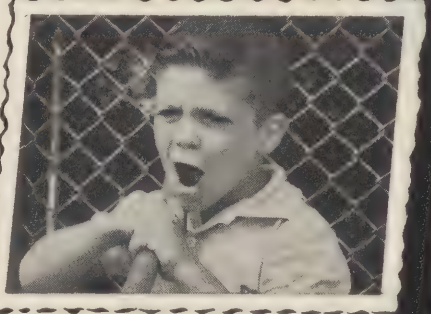
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"He couldn't swing a bat without hurting"



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permits uninterrupted sleep through the night

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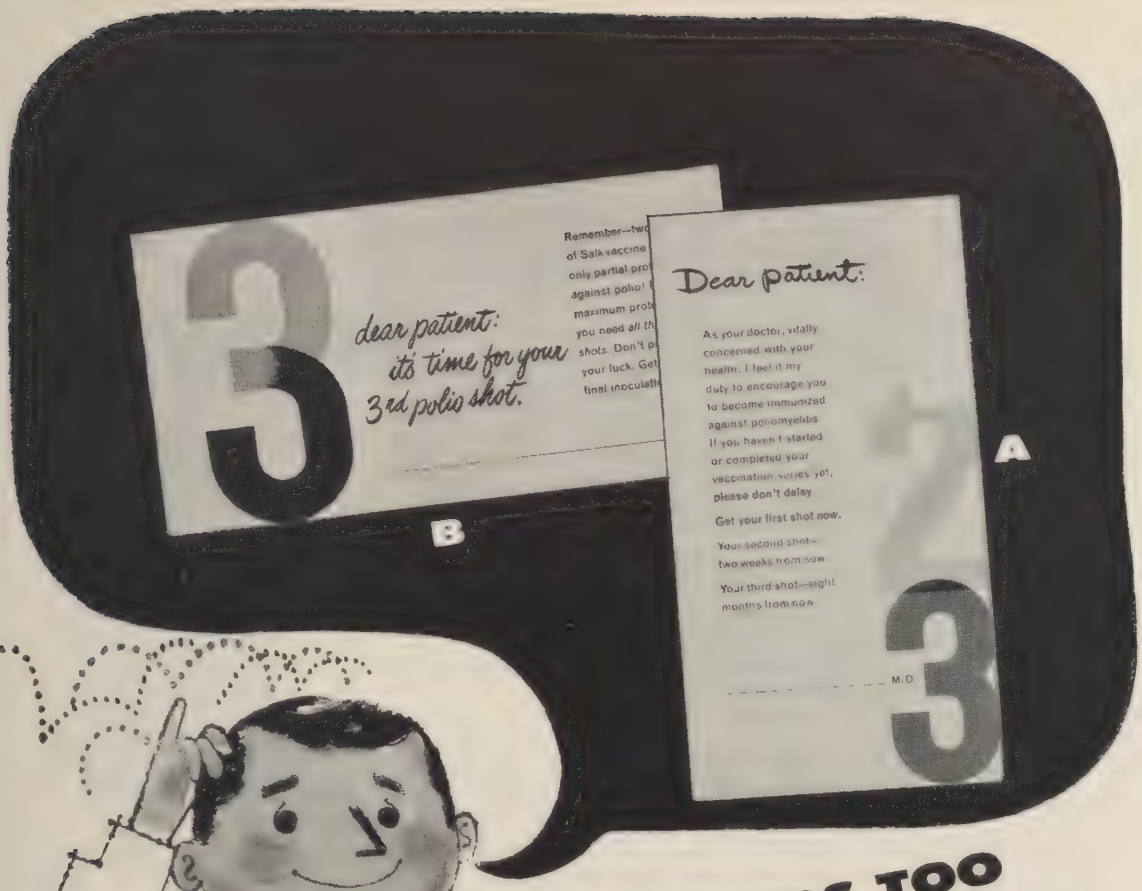
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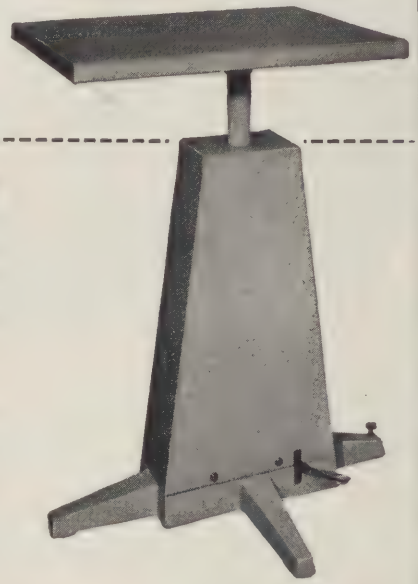
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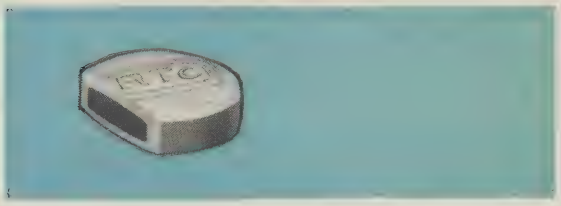
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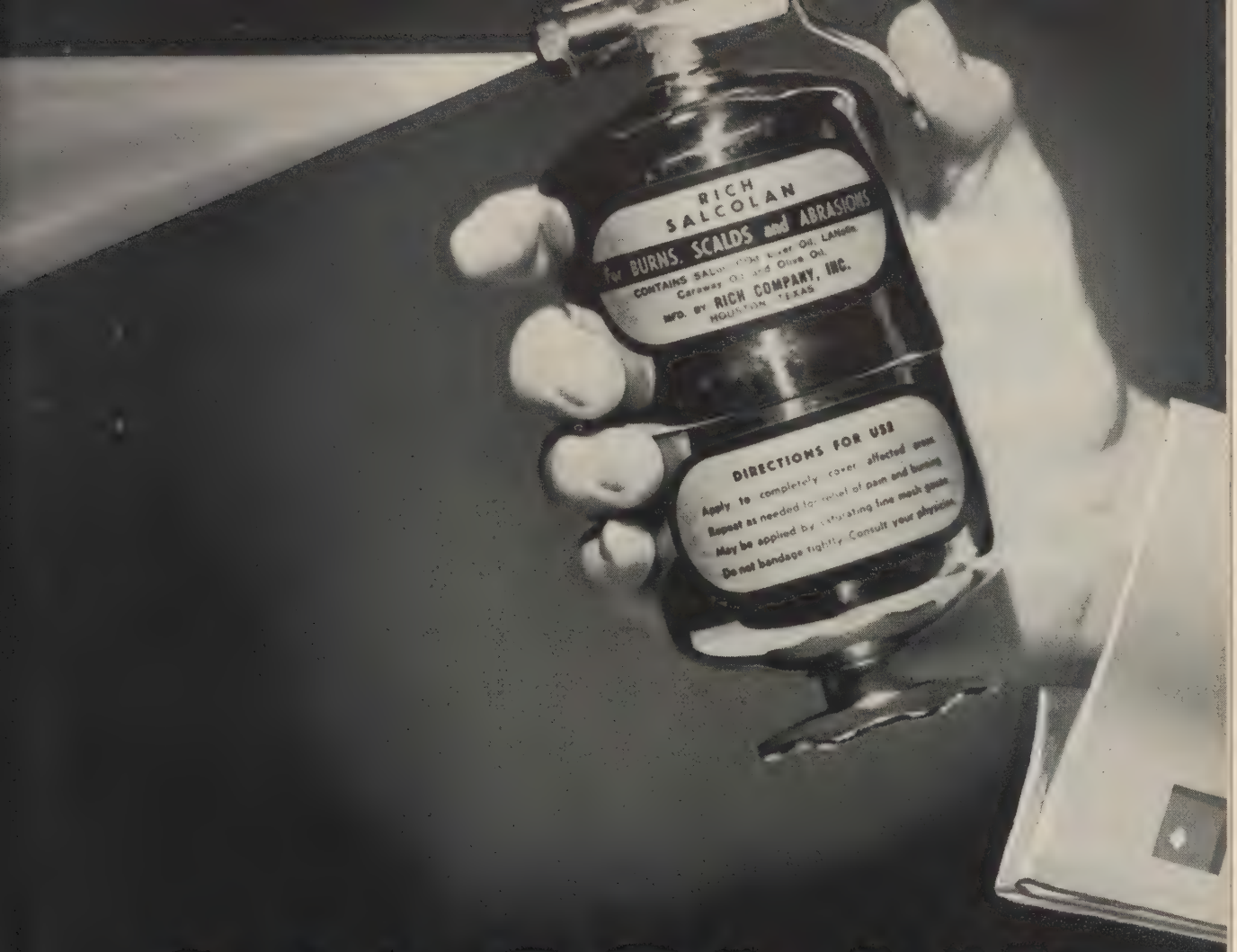
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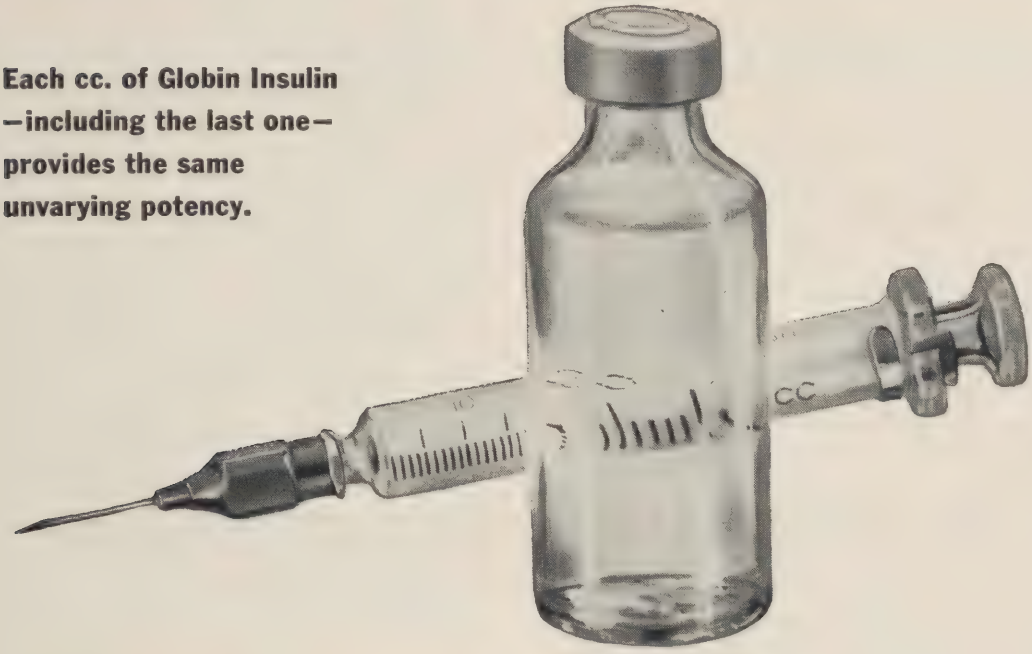
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Northern Tri-State Medical Association, Annual Meeting, May 8, South Bend, Ind.

Ohio State Surgical Association, Annual Meeting, Cincinnati, June 4 and 5.

Veterans Administration Clinical Conferences, Weekly on Wednesdays, 8:00 to 9:00 a. m., Cuyahoga Bldg., Cleveland.

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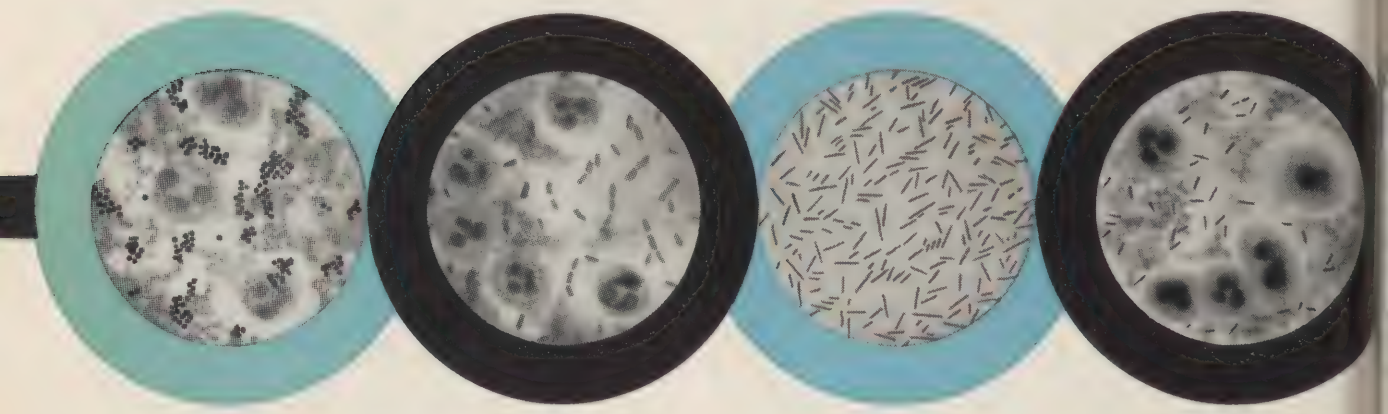
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Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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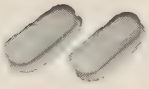
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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157:*126 (Jan. 8) 1955.

2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25:*182 (Feb.) 1956.

3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51:*1494 (June 15) 1956.

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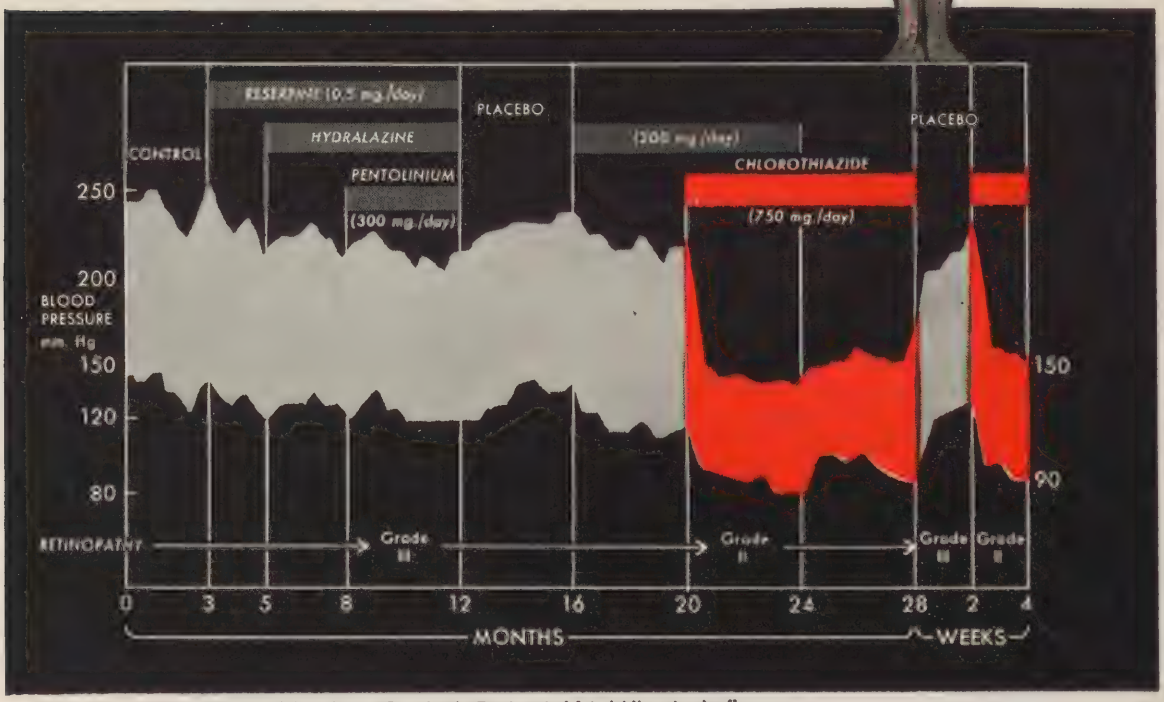
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."



Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

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1. Murphy, H. L., and Klasson, D. H.: New York St. J. M. 57:1908, June 1, 1957

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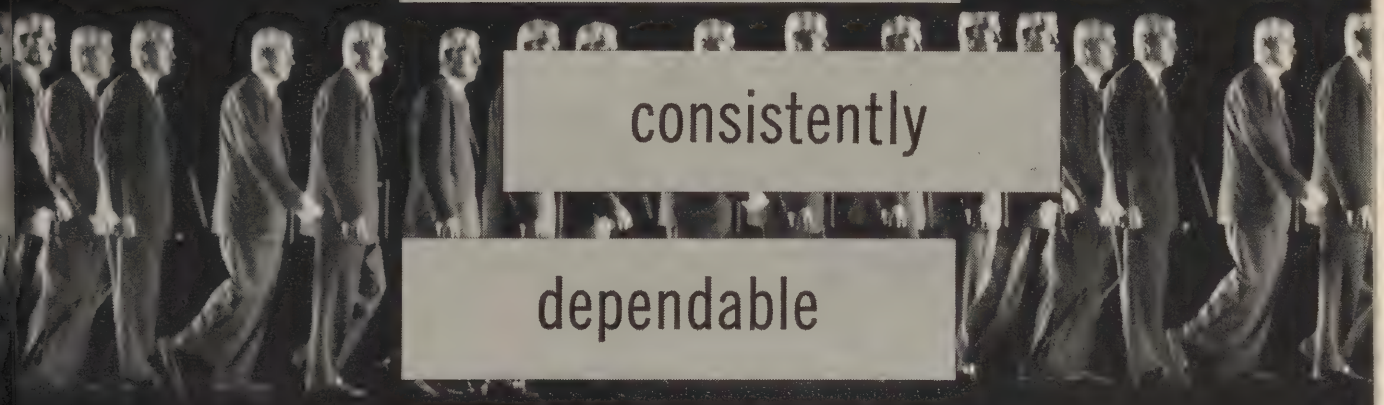
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

The World of Water, by J. Gordon Cook. ($3.00. *Dial Press, New York 16, N. Y.)* This is another in the series, Science for Everyman. Today water occupies the center of the stage in all agricultural and industrial conferences. It has become clear that water will be the limiting factor in population growth and in human health and prosperity.

This book tells the story of water as it enters into every aspect of human life and affairs. As everyone knows, it is used for drinking, for washing, for generating power and raising crops but water is also a most important industrial raw material and an extraordinary chemical in its own right. This distinguished chemist tells us about these aspects of water as well as its use in public health and in the atomic sciences.

A Casebook in Stuttering, by Charles Van Riper and Leslie G. Gruber. ($2.50, 149 pages. *Harper and Brothers, New York 16, N. Y.)* This study guides the students in advanced speech correction through the actual case history of a stutterer. It is intended to train students in advanced speech courses in stuttering diagnosis and therapy. It will find an important place in the courses in functional disorders of speech and in speech pathology.

Practical Dermatology, by Samuel M. Peck, M. D., and Laurence L. Palitz, M. D. ($7.00. *Landsberger Medical Book Co., Inc.,* distributed by the *Blakiston Division of McGraw-Hill Book Co., New York 36, N. Y.)* This book is designed to set clearly and concisely before the busy practitioner a survey of dermatologic disorders that are commonly met with in daily practice. The common dermatological problems are therefore discussed without reference to unusual conditions. It is a personal book, expressing the belief of these two distinguished authors.

Tranquilizing Drugs: A Symposium, arranged and edited by Harold E. Himwich, ($5.00. *American Association for Advancement of Science, 1515 Massachusetts Ave., N. W., Washington 5, D. C.)* A symposium is introduced by Dr. Chauncey Leake of the Ohio State University and reflects a nationwide concern over the possibilities of improvement of psychiatric treatment by means of new chemicals.

Experimental Psychology and Other Essays, by I. P. Pavlow. ($7.50. *Philosophical Library, New York 16, N. Y.)* The text represents a comprehensive anthology, some of the basic writings of the famous Russian physiologist and psychiatrist, winner of the Nobel Prize in physiology, with some rare pictorial material making it an excellent book for reference and for one's library.

Clinical Hematology, by Maxwell M. Wintrope, M. D. ($15.00, 4th Edition, thoroughly revised. *Lea & Febiger, Philadelphia 6, Pa.)* This book has been most thoroughly revised and brought up to date by the author, the distinguished hematologist and head of medicine at the University of Utah.

Diseases of the Endocrine Glands, by Louis J. Soffer, M. D. ($16.50, Second Edition, 1032 pages, 28 tables, 192 illustrations. *Lea and Febiger, Philadelphia 6, Pa.)* In this sound and well regarded work the author presents a detailed account of the physiological considerations in the various endocrine diseases met in the daily practice. The text covers all clinical syndromes and their complete management, including the currently accepted tests for function.

Practical Psychiatry for Industrial Physicians, by W. Donald Ross, M. D. ($7.50. *C. C. Thomas, Publisher, Springfield, Ill.)* This text by the associate professor of psychiatry and assistant professor of industrial medicine at the University of Cincinnati is designed to help the occupational physician improve his skill in the psychological and psychiatric aspects of preventive medicine by applying, in the course of his work, the methods which other experts have found to be effective.

The Happy Life of a Doctor, by Roger I. Lee, M. D. ($4.00. *Little Brown & Co., Boston 6, Massachusetts.)* This famous doctor tells his life story in a witty, modest and warmly personal way. He has had a distinguished career in American medicine and his reminiscences will prove most entertaining and informative to all who read his biography.

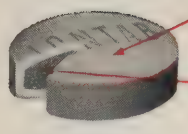
Meprobanate and Other Agents Used in Mental Disturbances, from the Annals of the New York Academy of Sciences, Vol. 67, Article 10, Pages 671-894. *(The New York Academy of Sciences, New York 21, N. Y.)* It is a monograph containing more than 20 hitherto unpublished papers on pharmacology, mode of action and the use of "Milltown." The papers were originally presented at an Academy conference under the title given above, and include reports on the

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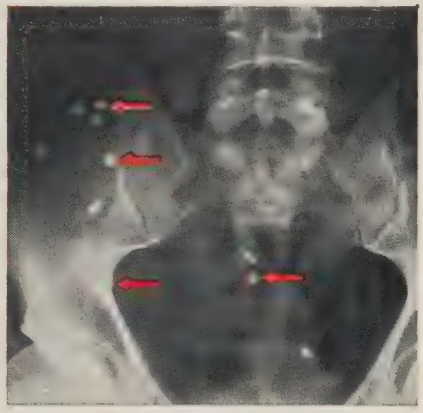
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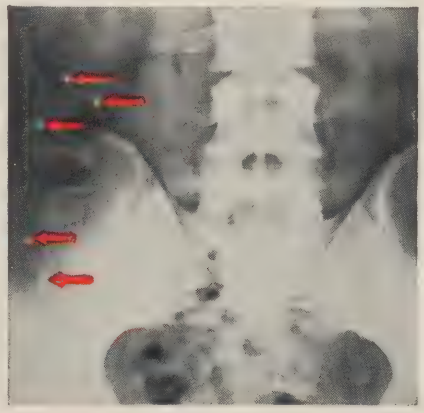
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



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use of the drug in the treatment of disturbed children, senile psychoses, muscle spasms, headaches, alcoholism, anxiety states, cerebral palsy and other conditions.

Urological Surgery, edited by Austin I. Dodson, M. D., with 9 contributors. ($20.00, Third Edition, 664 illustrations, 868 pages. *C. V. Mosby Co., St. Louis 3, Mo.)* This revision brings this well regarded text abreast with the advances that have occurred in the surgery of the urinary tract. The authors have attempted to include one or more procedures dealing with each surgical problem. In preparation of this work the editor has had the assistance of outstanding experts in the field.

Mastery of Stress, by Daniel H. Funkenstein, M. D., Stanley M. King, Ph. D., and Margaret E. Drolette, M. P. H. ($6.00, *Harvard University Press, Cambridge 38, Massachusetts.)* The healthy individual whose emotional responses, planning, thinking and physiological processes reflect the influence of society and culture provides a yardstick for understanding the diseased individual. This book is about a series of experiments conducted on a group of Harvard undergraduates, focused on the way these students reacted to certain new and different stress-inducing situations. Each man's emotional and physiological reactions were studied, with emphasis placed upon two phases of the stress reaction, the acute immediate reaction of emergency and the ability to master stress, or the failure, over a period of time.

The Placement of Adoptive Children, by J. Richard Wittenborn, assisted by Barbara Myers. ($4.75, *C. C. Thomas Publisher, Springfield, Ill.)* This book was written for the medical and legal professions, the clergy, social workers, adoptive parents and all persons who participate in the creation and maintenance of adoptive homes. It provides definite answers to the questions of central interest both to the adoptive parent and the placement worker.

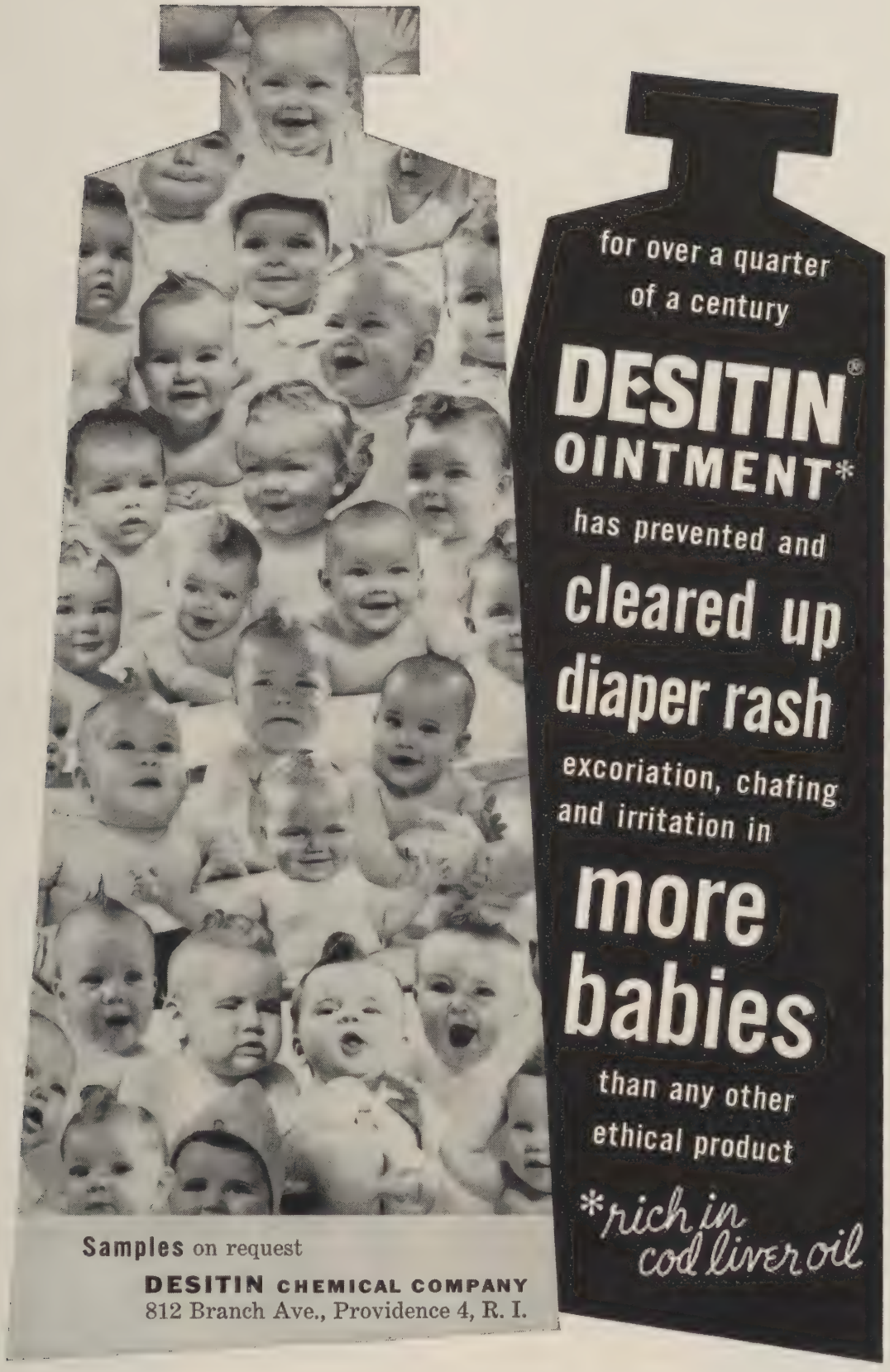
The Effects of the Sulfonylureas and Related Compounds in Experimental and Clinical Diabetes, a reprint from the Annals of the New York Academy of Sciences, Article 1, Vol. 61, pages 1-92. *(New York Academy of Sciences, New York 21, N. Y.)* This is a proceedings of a conference held by the Academy as a consequence of a deliberate and well planned research based upon a series of chance observations in a field far removed from diabetes. But for M. Janbom's fortuitous observations that one of his newer sulphanilimides of 1942 produced a disorder very similar to hypoglycemia, Auguste Loubatieres very probably would not have devoted the next 15 years in an effort to ascertain the nature of these symptoms and to analyze the mechanism which produced them. This particular series of drugs was also originally designed as more soluble sulpha drugs with prolonged action and their effect in diabetes was consequently an unexpected activity. All who are interested in this newer method of treating milder diabetes will want to see and study this book.

Practical Allergy: A Modern and Authoritative Guide to Diseases of Allergenic Origin, by M. Coleman Harris, M. D., and Norman Shure, M. D. ($7.50, *F. A. Davis Company, Philadelphia 3, Pa.)* Careful study of the individual patient is stressed by these authors as they clarify and simplify the important subjects of skin testing, studies concerning foods, pollens, drugs, bacterial, physical and insect allergy, allergy extracts, desensitization, in fact all the modern aides on the diagnosis and treatment of diseases of allergic origin. Sixteen valuable charts are included which are most helpful for the quick summarization of volumes of data. It is a very practical book that would serve as a useful text. It is also valuable since it covers all of the possible ideological factors in the most obstinate cases.

How To Enjoy Good Health, by Cyril Solomon, M. D., and Brooks Roberts. ($3.95, *Random House, Inc., New York 22, N. Y.)* It is a book authorized by the American Medical Association. Written by 67 prominent physicians, it is devoted and designed to give expert and easy-to-follow advice on the several aspects of points involved in the title.

Presentation of Technical Information, by Reginald O. Kapp. ($1.95, *Macmillan Company, New York 11, N. Y.)* Every medical man who writes reports or prepares manuscripts for publication with the hope that they will be read will find in this book ways to improve them and insure their receiving attention. The author tells you how to reach the minds of the people you write for by using style and psychology in your writing. He insists medical and other technical writing need not be dull. The author proves that you can produce easily understood technical material in an easy interesting manner and still be as accurate as you wish.

Modern Science and the Nature of Life, by William S. Beck. ($5.75, *Harcourt, Brace and Co., New York, 17, N. Y.)* The author, an investigator and teacher in the field of hemotology and atomic energy has written a most interesting book for the purpose of educating "my friends in science and to facilitate the exchange of ideas between people in different fields." The exploration of life is one of the most fascinating chal-


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lenges of science, says the author. The challenger throughout history has been the scientist himself. This brilliant study of both the scientist and his science carries the reader to the modern, perhaps ultimate frontier of the creation of living matter in the laboratory.

Our Astonishing Atmosphere, by J. Gordon Cook. ($3.00, *Dial Press, 461 4th Ave., New York 16, N. Y.)* This is one of the extraordinarily fine books in the series of science for every man. The series is designed to bring information on important scientific subjects to the man on the street to stimulate intelligent interest in science and to show how scientific research is affecting the lives of everyone. In this book the author, a Fellow of the Royal Institute of Chemists and well known for his work on synthetic rubber, plastics and fibres tells us what is now known about the atmosphere, the ocean of gas that envelops the earth in which human beings live like insignificant creatures at the bottom of a vast but flimsy sea. He tells of the clouds and the cosmic rays, of the wonderful gasses used by industry, and the difficulty of high speed flight, and describes how people's breath affects the world's climate and how the wind is being used for power. In these days of interest in air pollution here is a basic book from which to start one's reading and investigations.

The Stress of Life, by Hans Selye, M. D. ($5.95, *McGraw Hill Book Company, New York 36, N. Y.)* This internationally known authority on stress tells how he developed his now famous concept of stress. It brings to bear new light on the nature and effect of disease, how our bodies react to wear and tear of living and what we can do to adjust more harmoniously to such depletions of our adaptive energy.

Beyond Laughter, by Martin Grotjahn, M. D., ($6.00, *Blakiston Division, McGraw-Hill Book Co., New York 36, N. Y.)* This book by the famous psychoanalyst answers some of the problems concerning wit as a lonely man and gives us new insight into ourselves, our laughter and our literature.

Clinical Physiology: The Functional Pathology of Disease, by Arthur Grollman, M. D. ($12.50, *Blakiston Division of McGraw-Hill Book Company, Inc., New York 36, N. Y.)* In the preparation of this clinical physiology the basic principles are correlated with clinical medicine and systematically covered to aid the practitioner in the correct interpretation of the patient's symptoms and the proper treatment of the given disorder. It is the chief editor's firm belief that the physician's ability to diagnose and to prescribe is in direct proportion to his understanding of the physiological principles which underlie modern clinical practice. He says in his preface the physician of today cannot apply the knowledge available in medicine without a thorough understanding of the physiological principles upon which this knowledge is based.

Surgery: Principles and Practice, by J. G. Allen, M. D., Henry N. Harkins, M. D., Carl A. Moyer, M. D., and Jonathan E. Rhodes, M. D. ($16.00, *J. B. Lippincott Co., Philadelphia 5, Pa.)* In preparing this the authors have had the assistance of some 29 specialists, including Dr. Altemeire, of the University of Cincinnati and W. R. Culbertson, also of the University of Cincinnati. The idea behind this book was the need for a surgical text that included to a greater extent the physiologic, the biochemical, the pathological and the anatomic basis for surgical practice.

The Early Detection and Prevention of Diseases, by John P. Hubbard, M. D., ($7.50, *Blakiston Division of McGraw-Hill Book Company Inc., New York 36, N. Y.)* This volume represents a departure from the usual in that it deals extensively with the relation of preventive medicine to the clinical practice of the art rather than intensively with the aspects of a single disease or a single physiologic system.

Liver, Biliary Tract and Pancreas, by Frank H. Netter, M. D., part 3 of Vol. III, The Digestive System: The Ciba Collection of Medical Illustrations. ($10.50, *Ciba Foundation, Summit, New Jersey.)* These beautiful drawings prepared with the help of 5 distinguished authorities in the field give us a pictorial text of unusual value in the consideration of the digestive system.

Guide to Medical Writing: A Practical Manual for Physicians, Dentists, Nurses and Pharmacists, by Henry A. Davidson, M. D. ($5.00, *Ronald Press, 15 E. 26th St., New York 10, N. Y.)* This is an elementary text providing step by step guidance for basic writing technique for people in the medical field. It concentrates on practical details, showing how to organize subject matter, pin down ideas, put it all in readable form while mastering the mechanics of presentation.

The Care of the Expectant Mother, by Josephine Barnes. ($7.50, *Philosophical Library, New York 16, N. Y.)* This is a practical guide for all who undertake the management of pregnancy. The author is on the staff of the Charing Cross Hospital in London. The book is intended for those who make antenatal examinations and assist in helping the mother bear her children. The first section deals with normal pregnancy. The second

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section deals with abnormal pregnancies and the third gives an account of the diseases complicating pregnancy.

The Doctor As a Witness, by John E. Tracy. (*$4.25, W. B. Saunders, Philadelphia 5, Pa.)* An informative text designed to explain to the busy practitioner who has had little experience in court rooms the various kinds of legal proceedings in which he may be called upon to testify, how these proceedings are conducted, and what is expected from a medical witness when he takes the stand.

The Psychology of Sexual Emotion, by Vernon W. Grant, Ph. D., (*$4.75, Longmans Green and Co., New York 3, N. Y.)* The author is head of psychology in the Hawthornden State Hospital at Macedonia, Ohio. He brings together for the first time in organized form material from a variety of sources dealing with the emotional and esthetic as distinguished from the genital-sexual side of sexual attachment which received so much attention from Kinsey's report.

Reduce and Stay Reduced, by Norman Jolliffee, M. D., (*$3.50, Simon and Schuster, Inc., New York 20, N. Y.)* This revised edition brings significant developments of the past five years in the relationship of diet to coronary disease.

Hospital Treatment of Alcoholism, by Robert S. Wallerstein, M. D., and associates. (*$5.00, Basic Books Publishing Co., New York 3, N. Y.)* This is a comparative experimental study from the Winter V. A. Hospital at Topeka, Kansas. The author over a period of 30 months compared four different methods of treatment. In addition to tabulating the comparative results the authors have attempted to evaluate each with the personality of the patient.

Hypnosis in Medicine, by A. Philip Magonet, M. D. (*$1.00, Wilshire Book Company, Los Angeles 46, California.)* The author on the basis of his own experience attempts to integrate hypnosis with psychosomatic medicine, obstetrics and abnormal psychology.

Self Hypnosis, Its Theory, Technique and Application, by Melvin Powers. (*$2.00, 3rd ed., Wilshire Book Company, Los Angeles 46, California.)* This work is for the person who feels he has failed to show the world the full potentialities of his personality and success and starts going from one therapist to another.

The Leukemias, Etiology, Pathophysiology and Treatment, by J. W. Rebuck, Frank H. Bethell and Raymond Monto. (*$13.00, Academic Press, Inc., New York 3, N. Y.)* The fifth in the series of International Symposia sponsored by the Henry Ford Hospital in Detroit. These proceedings accomplish two purposes. It gives the present complex position of the problems with detailed information on the functions of the leukocyte and a comprehensive review of the therapy of leukemia. Secondly, it establishes a basis for comparative study of the progress which has been made.

Clinical Toxicology, The Clinical Diagnosis and Treatment of Poisoning, by S. Lockett, M.R.C.P. (London) (*$20.00, C. V. Mosby Company, St. Louis 3, Mo.)* This is a modern text written by a physician in active practice for physicians. In these days of promiscuous use of sprays and insecticides in food production, the use of so many industrial poisons, makes this book an important addition to the physician's library.

Illustrated Medical and Health Encyclopedia: Eight Volumes, by Morris Fishbein, M. D. (*$19.50, H. S. Stuttman Co., New York 16, New York.)* It is the aim of eight volumes to replace fear in the mind of the layman with knowledge. All entries are arranged alphabetically. With the aid of twenty-one distinguished authorities Dr. Fishbein has produced a dependable source of information for the layman in all topics from *Abdomen* to *Zyme.*

Goepp's Medical State Board Questions and Answers, by Harrison F. Flippin, M. D. (*$8.00, 9th ed., W. B. Saunders Co., Philadelphia 5, Pa.)* For 50 years now this has been a standard text for use in the preparation for state board examinations for medical licensure.

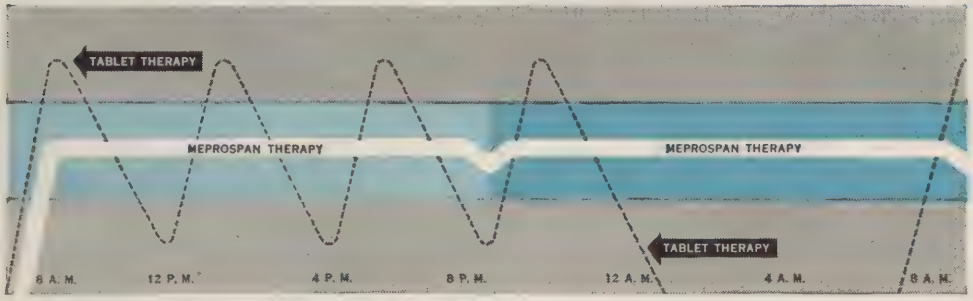
The Specialties in General Practice, by Russell L. Cecil, M. D., and Howard F. Conn, M. D. (*$16.00, 2nd ed., W. B. Saunders Co., Philadelphia 5, Pa.)* In this second edition, the editors have given the general practitioner a ready handbook of brief and practical descriptions of how to handle the less serious problems in the various special fields.

Your Wonderful Body, by Peter Pineo Chase, M. D. (*$5.95, Prentice-Hall, Inc., Englewood Cliffs, New Jersey.)* Rhode Island's "salty doctor" (and former editor of the *Rhode Island Medical Journal)* has given the layman a combination of doctor book and popular anatomy. It is intended for the general reader and is one that you can well recommend to them.

BCG Vaccination Against Tuberculosis, by S. R. Rosenthal, M. D. (*$7.50, Little Brown & Company, Boston 6, Mass.)* Contains chapter on immunity in tuberculosis; a review of the various vaccines; the safety of BCG preparation and standardization of the vaccine; various methods of administration and the pros and cons of its effectivenesses.

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In 1/2-oz. and 1/6-oz. tubes, 0.5% neomycin sulfate and 0.5% hydrocortamate hydrochloride (hydrocortisone diethylaminoacetate hydrochloride) — MAGNACORT.

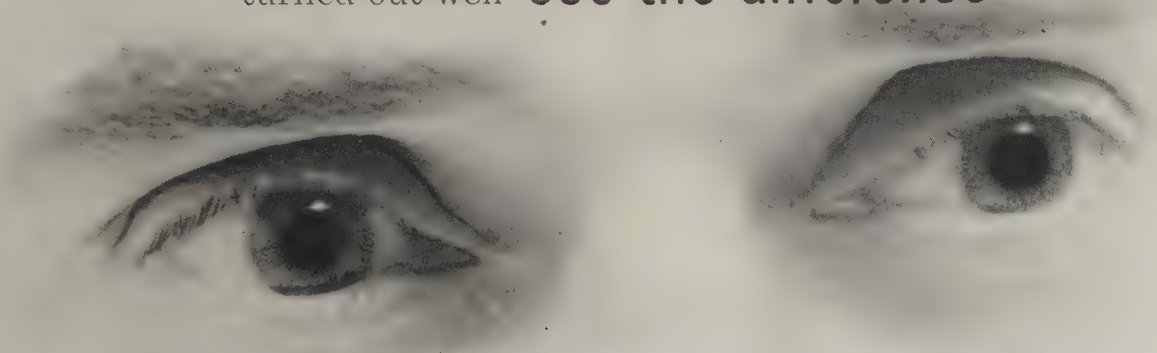
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*Howell, C. M., Jr.: Am. Pract. & Digest Treat. 8:1928, 1957.

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long day ahead
morning sun glare – eyes irritated
can't read – coach smoky
leave the work – let's lunch
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eyes comfortable – good TV play
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turned out well **see the difference**



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almost immediate relief of hyperemia, soreness, itching, burning, tearing — no rebound vasodilatation, mydriasis, photophobia or systemic effects. / *supplied: in 1/2 oz. bottles, 0.05% tetrahydrozoline hydrochloride in a solution containing sodium chloride, boric acid, sodium borate; with sterile eye dropper.*

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1. Grossmann, E. E., and Lehman, R. H.: Am. J. Ophth. 42:121, 1956.

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

AMA has gone on record supporting federal aid to help build and equip medical and dental schools, but opposes financial incentive to increase enrollment on grounds incentive might tempt schools to accept more students than they can properly train.

* * *

American Hospital Association has advocated Hill-Burton program for coming fiscal year be increased to $201-million, an increase of $80-million.

* * *

Labor Secretary Mitchell, addressing AFL-CIO national conference on workmen's compensation (called to lay groundwork for model Federal workmen's compensation act) said best way to improve such laws is to work with state legislatures.

* * *

Dr. Thomas H. Alphin, director of AMA's Washington office since November 1955, has resigned to become associate medical director of the Equitable Life Assurance Society, New York City. Dr. William J. Kennard, deputy director, has been named acting director of the office. He joined the AMA in 1955 after his retirement as brigadier general in the Air Force Medical Corps.

* * *

National Science Foundation survey shows nearly two-thirds ($500-million) of all money for research and development work at colleges and universities comes from Federal government, mostly for defense and similar projects. NSF wants such grants to be "explicitly and completely disassociated" from the institutions' budgetary crises, and of more than a year in duration to assure continuity of activity."

* * *

Atomic Energy Commission has awarded 40 continuation and six new contracts for investigation into life sciences, with 20 in medicine. Western Reserve University, with $201,791 contract, was one of two schools to receive six-figure awards. University of Utah received $271,753.

* * *

More regard on the part of manufacturers for safety factors in auto construction was advocated in Washington by Dr. F. D. Woodward, chairman of the AMA committee on medical aspects of automobile injuries and deaths, who said safety equipment, such as seat belts, crash padding and improved steering wheels, are all too often made available as optional equipment at extra cost.

* * *

Dr. John R. Heller, head of the National Cancer Institute, has reported that recent developments "are serving to indicate the places where important breakthroughs may be expected. . . . These breakthroughs may lead to better understanding of origin and nature of cancer; they may open direct and short paths to drug cures; they may point the way to widespread prevention through immunization. . . ."

* * *

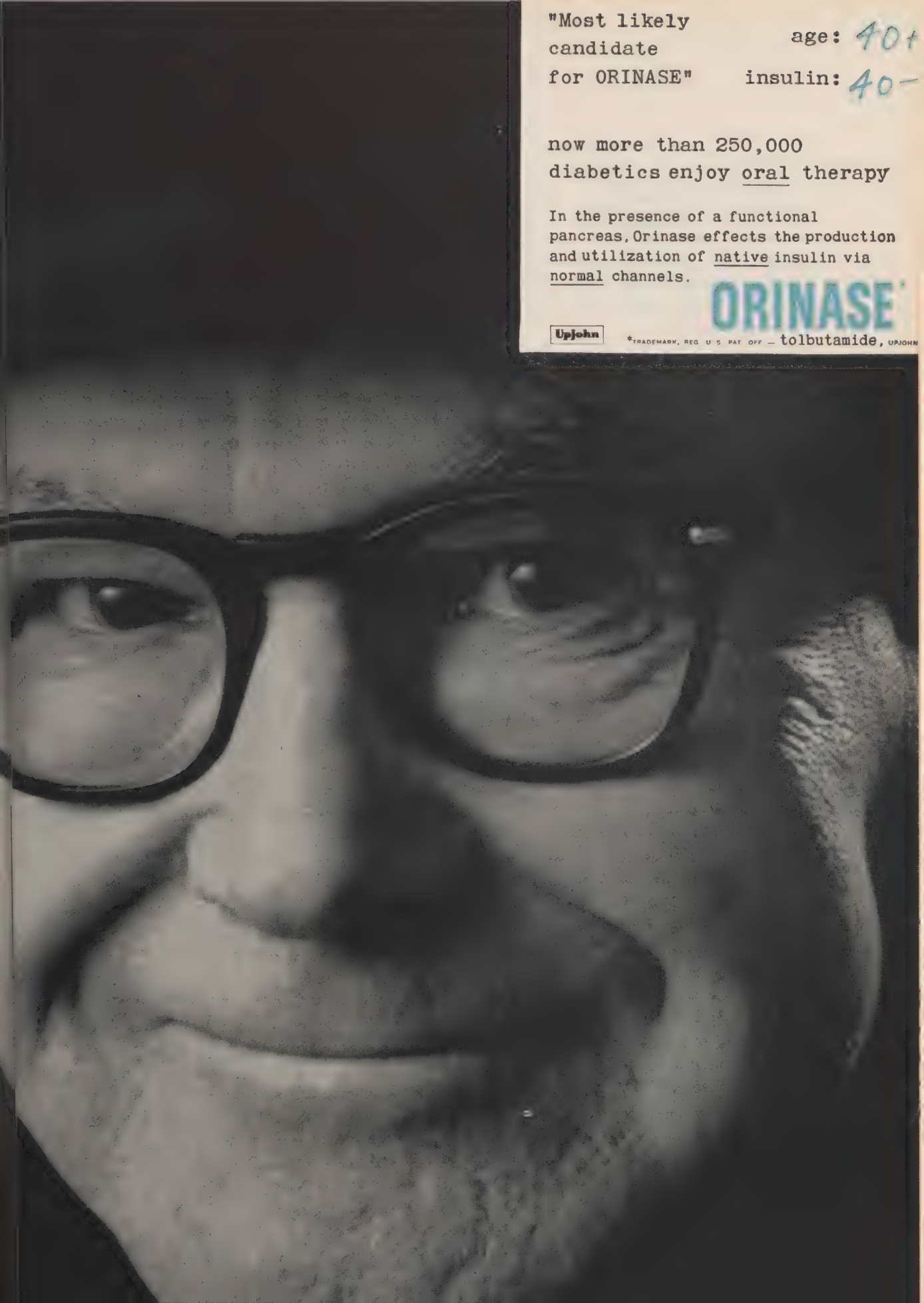
AMA has asked for stronger medical department in Civil Aeronautics Administration, contending that the department currently is subordinated in the CAA and medical issues are being settled by the Civil Aeronautics Board, which does not have qualified medical personnel. AMA said physical standards and medical evaluation of fliers should be handled by physicians experienced in aviation medicine, and that an office of civil air surgeon is needed within the CAA.

* * *

U. S. National Health Survey, in first detailed report, shows through projection of three-month sampling that an estimated 199-million physician visits were made in the U. S. from July 1 to September 29, 1957, giving an annual rate of 4.8 visits. Rate for females of all ages was 5.5 per cent; males, 3.9. Two of three visits were in doctor's office and only eight per cent in patient's home.

* * *

Internal Revenue Service, clarifying conditions under which tax-deductible travel may be directed by a physician, held as deductible expenses of elderly patient with arteriosclerotic heart disease who was advised by his doctor to go to a specific location where temperature was suitable and proper medical care available. Physician also banned further travel or sightseeing, and advised a nurse accompany him. IRS ruled expenses of patient and his nurse deductible since it was to alleviate specific ailments and not just for general health improvement.



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Relieves Respiratory Discomforts Caused by Dust and Dirt Irritants In the Home

Patients with dust allergies frequently experience marked discomfort during home cleaning activities due to dust and dirt in the air. The Filter Queen Home Sanitation System relieves such distress by removing the cause. It operates on an entirely different principle—really two principles in one. First, by means of an unique, exclusive *Sanitary Filter Cone* it actually filters the air, cleans it by aeroscopic action of the smallest particles, even matter as fine as smoke. Second, the Filter Queen *Centrifugal Chamber* traps all matter collected, positively eliminates scattering or dispersion of dust in room air. Unbiased scientific proof of Filter Queen's air purifying efficiency is shown in a recent report* from the Biological Sciences Department of an eastern university which states, *"The Filter Queen cellulose Filter Cone removes practically all dust and atmospheric pollen."* This is another reason why Filter Queen has been selected for use in many of America's leading hospitals.

A Filter Queen demonstration in your home or office can be easily arranged at no obligation by writing or calling your local Filter Queen distributor.

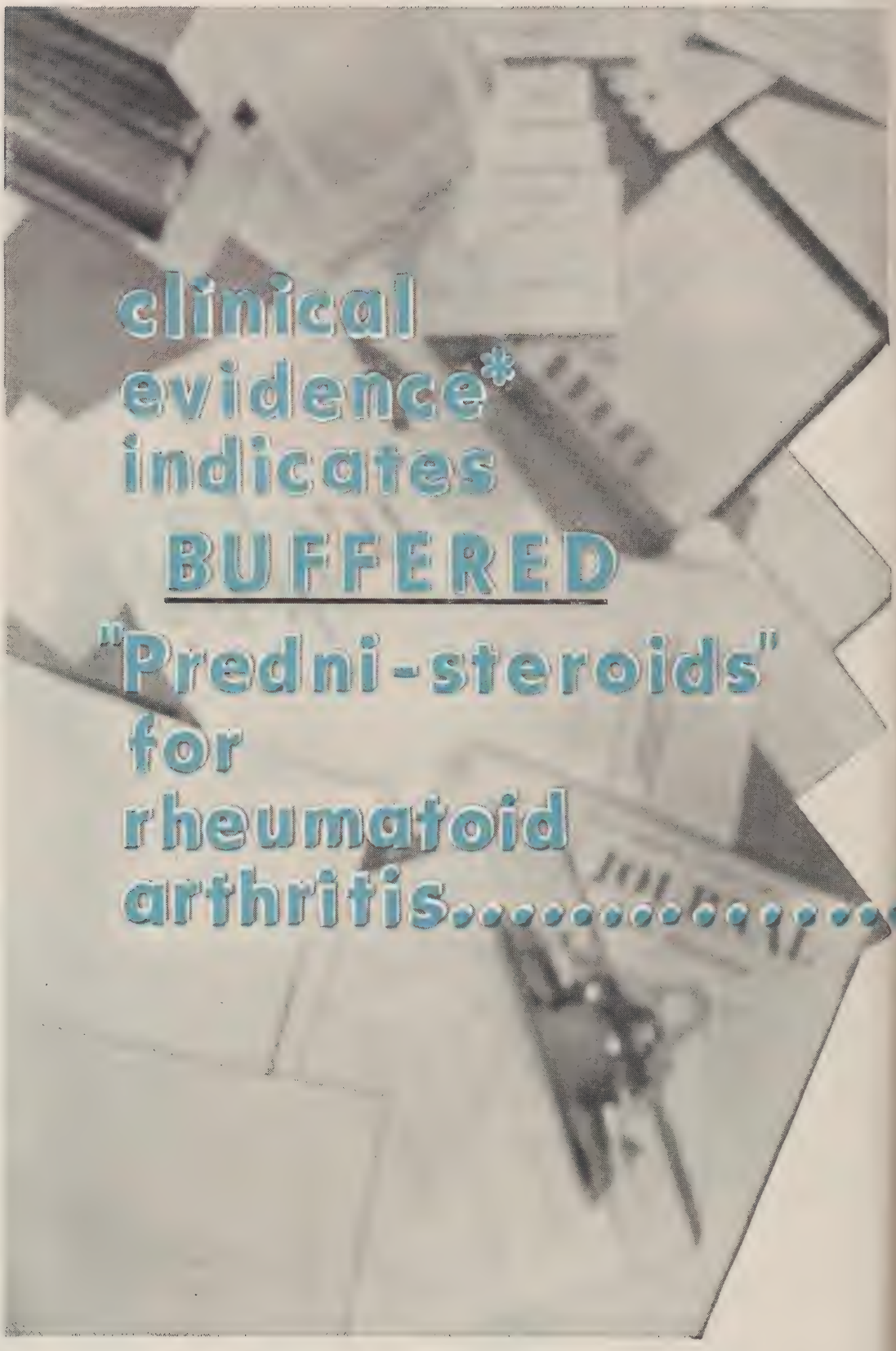


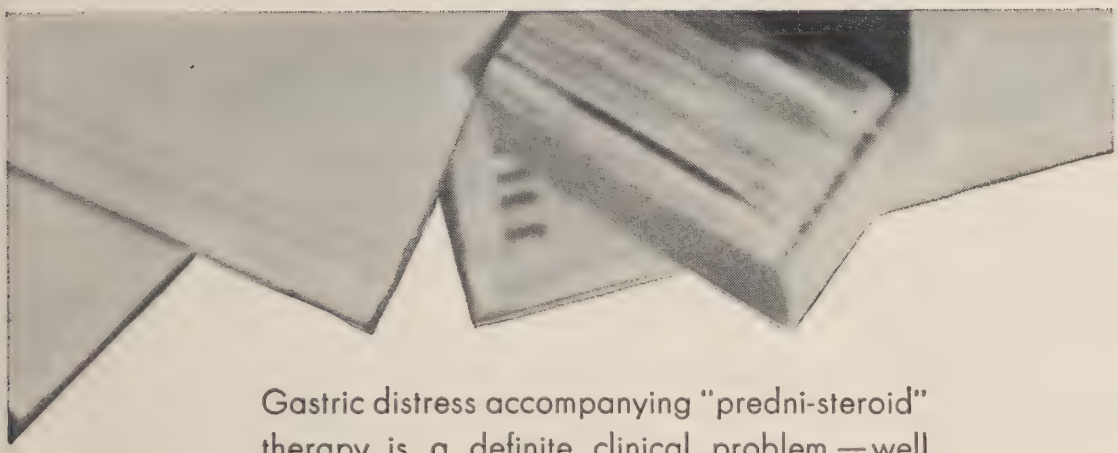
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*"In view of the beneficial responses observed when antacids and bland diets were used concomitantly with prednisone and prednisolone, we feel that these measures should be employed prophylactically to offset any gastrointestinal side effects."—Dordick, J. R. *et al.*: N. Y. State J. Med. 57:2049 (June 15) 1957.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

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PREDNISONE BUFFERED

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provide all the benefits of "Predni-steroid" therapy—plus positive antacid protection against gastric distress

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2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. magnesium trisilicate, in bottles of 30, 100, 500.

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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

AMA Meeting in Grand Rounds Telecast

A 90-minute closed circuit television program emanating from the AMA's annual convention in San Francisco will be transmitted to physician audiences gathered in Boston, Chicago, Cleveland, Kalamazoo, Philadelphia, New York and Syracuse. The program will be presented Wednesday, June 25, from 6:00 p. m. to 7:30 p. m., PDT, by the Upjohn Company in cooperation with the American Medical Association. Physicians attending the convention will be able to view this program in the Civic Auditorium area.

The first 30 minutes of the telecast will be devoted to a report on outstanding highlights of the scientific meeting, including excerpts from some of the papers and a brief tour of the Scientific Exhibit. The remaining 60 minutes will be in the form of a Grand Rounds clinical session on the subject of diabetes.

Committee Studies AMA's Basic Programs

One of the first projects of the Committee to Study AMA Objectives and Basic Programs will be to send out a questionnaire inviting suggestions and criticisms of the Association. This questionnaire will be based on the following four points which were listed by the House of Delegates when the committee was organized last December: (1) Redefining the central concept of AMA objectives and basic programs; (2) placing more emphasis on scientific activities; (3) taking the lead in creating more cohesion among national medical societies, and (4) studying socioeconomic problems.

The questionnaires will be sent not only to state and county medical societies, specialty groups and other national medical organizations, but also to a probability sample of more than 3,000 physicians chosen systematically from the new *AMA Directory*. The latter sample will include both AMA members and nonmembers.

Helping Hands Go into New Career Film

A little seven-year-old youngster is helping influence students to choose a career on the health team. She's Julie Morgan, the star of a new 16mm medical health career recruitment film produced by the American Medical Association, the American Hospital Association and E. R. Squibb and Sons. "Helping Hands for Julie" tells the dramatic story of the fight to save Julie's life. The helping hands aiding the doctors in finding the correct diagnosis of meningitis are those of the nurses, medical technologists, x-ray technicians and medical record librarians. With the diagnosis made, the drugs of the pharmacist, the nourishing food of the dietitian, the restorative work of the physical therapist, and the care of the nurses bring Julie back to health.

Medical societies and auxiliaries may arrange for bookings of this 30-minute black and white sound film through AMA's Film Library after July 1.

Voluntary Health Insurance For the Aged

An article in the April, 1958, issue of the *Chronic Illness Newsletter,* published bi-monthly by the AMA Council on Medical Service, describes some of the methods by which persons over 65 are being increasingly included in voluntary health insurance coverage. The article breaks down various groups within this over-65 population by type of protection or lack of it, describes a number of the programs currently under way by the Blue Shield-Blue Cross plans, private insurance companies, industry and others in extending voluntary health protection for these groups, and analyzes the socioeconomic forces behind a rising trend in coverage of this section of the population. Additional copies of this issue of the *Newsletter* are available on request from the Council.

Revises Prepayment Brochure

Copies of the new edition of AMA's booklet, "Voluntary Prepayment Medical Benefit Plans," will be available from the Council on Medical Service early in June. In addition to a description of plans having medical society approval, this edition of the brochure will contain data on the growth of such plans and a resumé of new developments in the field. As in the past, a supplement of "Charts and Graphs" will accompany the brochure.

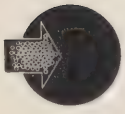
Health Shows for Radio are Being Used

AMA's health messages are reaching the American people via radio. A glance at the latest Bureau of Health Education report shows that 574 sets of AMA transcriptions were in the hands of local broadcasters throughout the country on April

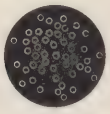
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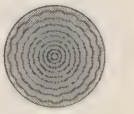
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EASES EVACUATION

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PROVEN SAFE...EFFECTIVE • IN PREGNANCY • IN CHILDHOOD • IN MIDDLE-AGED PATIENTS • IN ELDERLY PATIENTS • **THROUGH MORE THAN 25 YEARS OF USE**

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0.66 Gm. non-bitter Ext. Cascara per tablespoonful.
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0.13 Gm. (2.2 gr.) phenolphthalein per tablespoonful.
Bottles of 1 pint.

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70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

28, 1958. Since there are 13 programs in each set, this represents approximately 7,500 local broadcasts which have been, are being, or will be made from these transcriptions. Some of the most popular series include "Menu for Health" (45 sets), "Harmony and Health" (46 sets), and "Interlude" (28 sets). Not included in these figures are the monthly platters entitled "Health Magazine of the Air."

Committees on Aging Now Have Guide

"Suggested Guides for Medical Society Committees on Aging" is the title of a new booklet being prepared by the AMA's Committee on Aging for use by state and county medical societies. The booklet contains suggestions as to (1) purposes of a medical society committee on aging; (2) membership and format; (3) tenure of members; (4) meetings; and (5) activities. Copies of the pamphlet will be available from the Council on Medical Service.

New Report Issued on Indigent Care

A new report titled "Medical Care for the Indigent in 1957" has been prepared by the Committee on Indigent Care of the AMA's Council on Medical Service. This report deals with some of the specific problems that states have encountered under current laws. Two previous reports in the series have dealt with the development of Public Assistance medical care and the changes made by 1956 and 1957 amendments to the program.

Effective July 1, 1957, new federal matching funds were authorized to reimburse the states for part of the cost of providing medical services to recipients of old age, blind, and permanent and total disability assistance, and of aid to dependent children. However, these additional funds could be applied only to payments made directly to the providers of medical services—physicians, hospitals, pharmacists, etc. States applying for these funds could receive federal aid, outside the limits set by this new formula, only for payments made directly to assistance recipients.

In a number of states which had already provided comprehensive medical care for Public Assistance recipients, this new formula required considerable reorganization of the program if maximum federal aid was to be achieved. The Committee's new report examines in detail the problems raised for these states and the federal policies affecting methods of paying for medical services.

The first two reports now are available in reprint form, and the new report will be available shortly from the Council on Medical Service.



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- relieves anxiety, irritation, fatigue
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SUPPLIED: Bottles of 100 scored tablets.

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70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

INCOME TAX DEDUCTIONS FOR CONVENTION EXPENSES

Going to take in a medical convention this Summer or Fall?

If so it would behoove you to read carefully and observe the advice in the following statement issued by the AMA about how to get along with the income tax authorities with regard to deductions in attending such meetings, in reply to a question concerning the AMA meeting in San Francisco and a post-convention tour (with wife) to Hawaii:

"The expenses of a practicing physician in attending a medical meeting as well as conventions of his medical association are generally recognized as deductible by the Internal Revenue Services. Deductible expenses include registration fees if any; lodging; meals; and transportation, but they do not include personal expenses such as the cost of entertaining personal friends or sight-seeing. If a wife accompanies her husband, the portion of the expense attributable to her travel, meals, and lodging are not deductible, unless it is established that her presence was necessary and served a bona fide business purpose. Physicians ordinarily cannot provide such proof.

"The Internal Revenue Service is very skeptical about allowing tax deductions for overseas travel, particularly to resort areas. The Hawaii Summer Medical Conference will undoubtedly provide many educational opportunities to visiting physicians from the mainland, but if your primary purpose in going to Hawaii is to take a vacation your expenses will not be allowed. Among the factors which are taken in consideration in determining whether the primary purpose of a trip is personal or business is the proportion of time devoted to recreational activities and sight-seeing and the fact that you are accompanied by your family."

CHANGE IN LOCATION AND AMA MEMBERSHIP

If an Ohio physician moves his practice to another state where a probationary period is required before he can affiliate with the medical societies in that state, is there any way where the physician can continue his AMA membership during the probationary period?

Here is the answer:

If the physician has paid dues in Ohio for the current year, his local, state and AMA membership for that current year will not be disrupted. However, at the end of the current year, he will have to look to a special provision of the AMA Constitution and By-Laws for keeping himself in good standing in medical organization.

Under the AMA provision, the physician who has made application for membership in a new state or territorial medical society and a waiting period is required before action is taken on the application, he may continue his AMA membership by sending dues directly to the secretary of the AMA. However, this practice can be followed for only two years. If the application has not been processed within this period, the physician's name must be removed from the roster of AMA members.

The suggested procedure for sending dues directly to the secretary of the AMA is as follows:

1. The physician should ask the secretary of his state or territorial medical society to notify the AMA (and send a carbon copy to the physician) that he has made an application to continue membership through his state or territorial medical society but that it cannot be processed before a given date.

2. AMA membership dues should be sent, with the carbon copy of the letter received from the secretary of the state or territorial medical society, to the secretary of the AMA. This procedure will permit AMA membership to be uninterrupted.

DEATH CERTIFICATES SHOULD BE FILLED OUT PROMPTLY

Complaints that some doctors are not prompt in completing death certificates was the subject considered recently by the Interprofessional Relations Committee of The Toledo Academy of Medicine.

Pointing out that "this would seem to be a simple problem to solve," the *Toledo Academy Bulletin* has this to say:

"All physicians know that they are required by law to certify the causes of death of patients who have been under their care. It may not be so well known that delay in completing the death certificate can cause postponement of burial.

"Burial permits are issued to funeral directors by the Registrar of Vital Statistics, and he is directed by state law not to issue such permits until satisfactory medical certification is filed. Because of this requirement, funeral directors find it necessary to do the "leg work" in obtaining the death certificate from the doctor.

"Although most doctors are courteous and prompt in filling out death certificates, numerous complaints have been received by the Registrar of Vital Statistics that

funeral directors are required to wait unreasonable periods of time for the certificate, or that some doctors refuse to complete the certificate at the time, saying it can be picked up later, or it will be forwarded by mail.

"If doctors are made aware of the burial permit requirement stated above, and if funeral directors will telephone for a satisfactory time to find the doctor in his office, the certificate can be filled out in most instances within a few minutes after it is placed on the doctor's desk.

"The death certificate is a standardized form used throughout this country and in many other parts of the world. It requires certification of the major disease category which caused death. Rarely, if ever, must the doctor use the excuse of waiting for the autopsy report before such a document can be completed.

"Physicians are requested and urged, in the interest of better professional relations, and in behalf of families who need copies of the death record, to be prompt and courteous in fulfilling this small but important obligation. We are sure that greater cooperation by funeral directors will be forthcoming if this cause for complaint is eliminated."

We concur heartily in the editorial comment of the *Toledo Academy Bulletin,* and would add that prompt filling out of death certificates is not only important for good interprofessional relations, but also extremely important from the standpoint of good public relations.

CLEVELAND SEEKS SOLUTION FOR "MEDICAL EXPERT" PROBLEM

The Cleveland Academy of Medicine has launched a move designed to straighten out the situation of medical expert testimony. More power to it! This is a situation which needs plenty of therapy. Treatment can be administered locally better than in any other way, in our opinion.

The following editorial in the May issue of the *Cleveland Academy Bulletin* tells the story:

A large proportion of the cases tried in the courts of Cuyahoga County are claims for damages alleged to have been sustained as a result of personal injury. In the majority of these, medical evidence is required to establish that an injury was sustained and that the ensuing disease or disability suffered by the plaintiff was caused or contributed to by the injury.

"Many, if not the majority, of these cases would never reach the courts were it not for the fact that doctors have disagreed (a) as to the relationship between the injury and the damage alleged to have been caused by it or (b) as to the extent and nature of the damage. The usual situation is that one or more physicians retained by the claimant testify that in their opinion the disability or disease for which compensation is claimed was caused or contributed to by some specific episode of stress or injury for which the defendant is responsible. One or more physicians retained by the defendant testify that the evidence does not warrant such a conclusion. Under the prevailing system, each litigant employs his own medical witnesses. It is fair to assume that a witness whose opinion, right or wrong, is not in accord with the interests of the litigant who interviews him, will not be employed.

"Sometimes the situation is one in which there is room for honest differences of opinion. More frequently there would be no significant difference of opinion if the medical facts were submitted to a panel of unbiased medical experts for evaluation.

"For many years the situation has troubled the officers and directors of the Academy of Medicine. Recently the President of the Academy has appointed a committee to act in conjunction with a similar committee of the Cleveland County Bar Association to seek a solution to this problem. Consideration is being given to the establishment of a panel of medical experts similar to those in existence in New York and in Baltimore to provide the courts with a means of getting competent and unbiased medical opinion.

"In the meantime, it is the intention of the Academy's committee to publish in the *Bulletin* from time to time verbatim transcripts of the kind of medical testimony that physicians are giving in the courts of Cuyahoga County in personal injury claims. The testimony, together with the name of the doctor who gave it, will be published exactly as taken from the transcript of the court record and without editorial comment. It is hoped that the publication of examples both of biased and of unbiased medical testimony will be of educational value to the readers of the *Bulletin.*"

The plan to publish the transcript of testimony offered by medical experts may have a helpful effect. Those who give unbiased medical testimony will have nothing to fear. Those who cut the corners will be exposed which they probably won't like.

SUMMIT COUNTY DOCTORS DISPLAY CIVIC SPIRIT

Members of the Summit County Medical Society recently demonstrated capably the belief that a physician's interest and activities in his community should extend beyond the medical aspects.

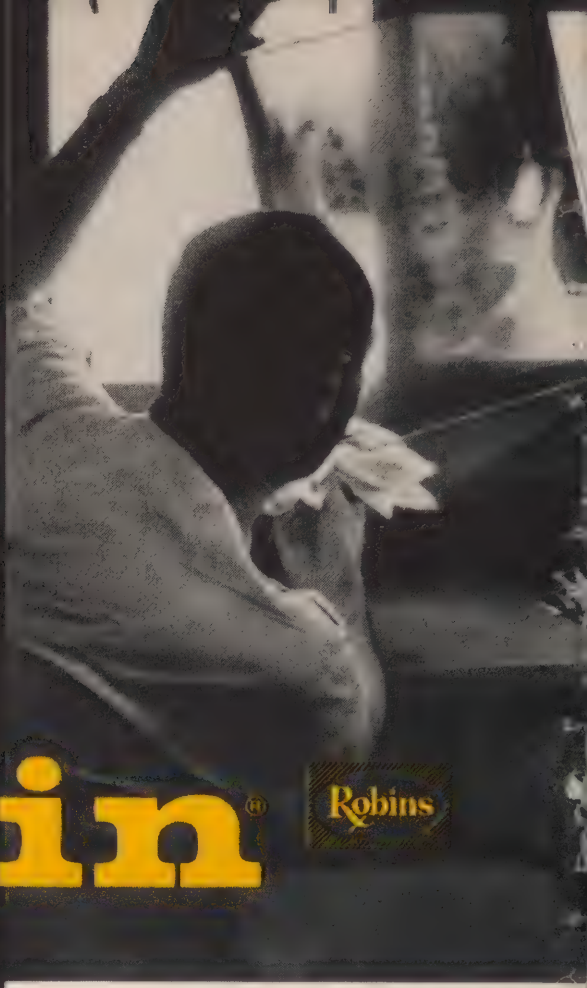
The society organized six teams totaling 40 physicians to carry out the society's portion of a campaign to raise $1,247,400 for the Akron YMCA. These doctors thereby recognize that a community has not only the physical health of its residents to consider but also its moral, mental and sociological health.

By their actions, members of the Summit County Medical Society have increased the stature of their profession and their society in the eyes of their fellow citizens.

NEW published reports of clinical studies show:

Decisive skeletal muscle relaxation with Robaxin®

Methocarbamol Robins U.S. Pat. No. 2770640



"Excellent,"[5] "marked,"[1] "pronounced"[4] or "significant"[6] results in 75.3% of cases of acute skeletal muscle spasm, and moderate results in 20.3% – or an over-all beneficial response in 95.6%. Other important advantages:

- **Highly potent and long acting.**[2,3,4,6,7,8]
- **Relatively free of adverse side effects.**[1,2,3,6]
- **In ordinary dosage does not reduce normal muscle strength or reflex activity.**[6]

Summary of four published clinical studies

ROBAXIN BENEFICIAL IN 95.6% OF CASES

CONDITION	NO. PATIENTS
STUDY 1[1]	
Skeletal muscle spasm secondary to acute trauma	33
STUDY 2[2]	
Herniated disc	39
Ligamentous strains	8
Torticollis	3
Whiplash injury	3
Contusions, fractures, and muscle soreness due to accidents	5
STUDY 3[5]	
Herniated disc	8
Acute fibromyositis	8
Torticollis	1
STUDY 4[6]	
Pyramidal tract and acute myalgic disorders	30
TOTALS	138



F ACUTE SKELETAL MUSCLE SPASM[1,2,5,6]

RESPONSE			
"marked"	*moderate*	*slight*	*none*
26	6	1	—
"pronounced"			
25	13	—	1
4	4	—	—
3	—	—	—
2	1	—	—
3	2	—	—
"excellent"			
6	2	—	—
8	—	—	—
—	—	1	—
"significant"			
27	—	2	1
104	28	4	2
(75.3%)	(20.3%)		

Comments on Robaxin by investigators

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamo has afforded greater relief of muscle spasm and pai for a longer period of time without undesirable sid effects or toxic reactions than any other commonl used relaxants . . ."[2]

THE JOURNAL
American Medical Association

"An excellent result, following methocarbamol ad ministration, was obtained in all patients with acut skeletal muscle spasm."[5]

THE JOURNAL
American Medical Association

"In no instance was there any significant reductio in voluntary strength or intensity of simple reflexes."[

Southern Medical Journal

"This study has demonstrated that methocarbamo (Robaxin) is a superior skeletal muscle relaxant i acute orthopedic conditions."[1]

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●

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References: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B.: Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm & Exper. Therap. 119:189, 1957

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Unprecedented Low Dosage. Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. (1 to 2 tablets) maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides —a notable asset in prolonged therapy. [2]

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KYNEX*

Sulfamethoxypyridazine Lederle



Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

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References: 1. Grieble, H. C. and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958. 2. Editorial *New England J. Med.* 258:48-49, 1958. 3. Jones, W. F., Jr. and Finland, M., Sulfamethoxypyridazine and Sulfachloropyridazine. *Ann. New York Acad. Sc.* 60:473-483, 1957.

*Reg. U. S. Pat. Off.

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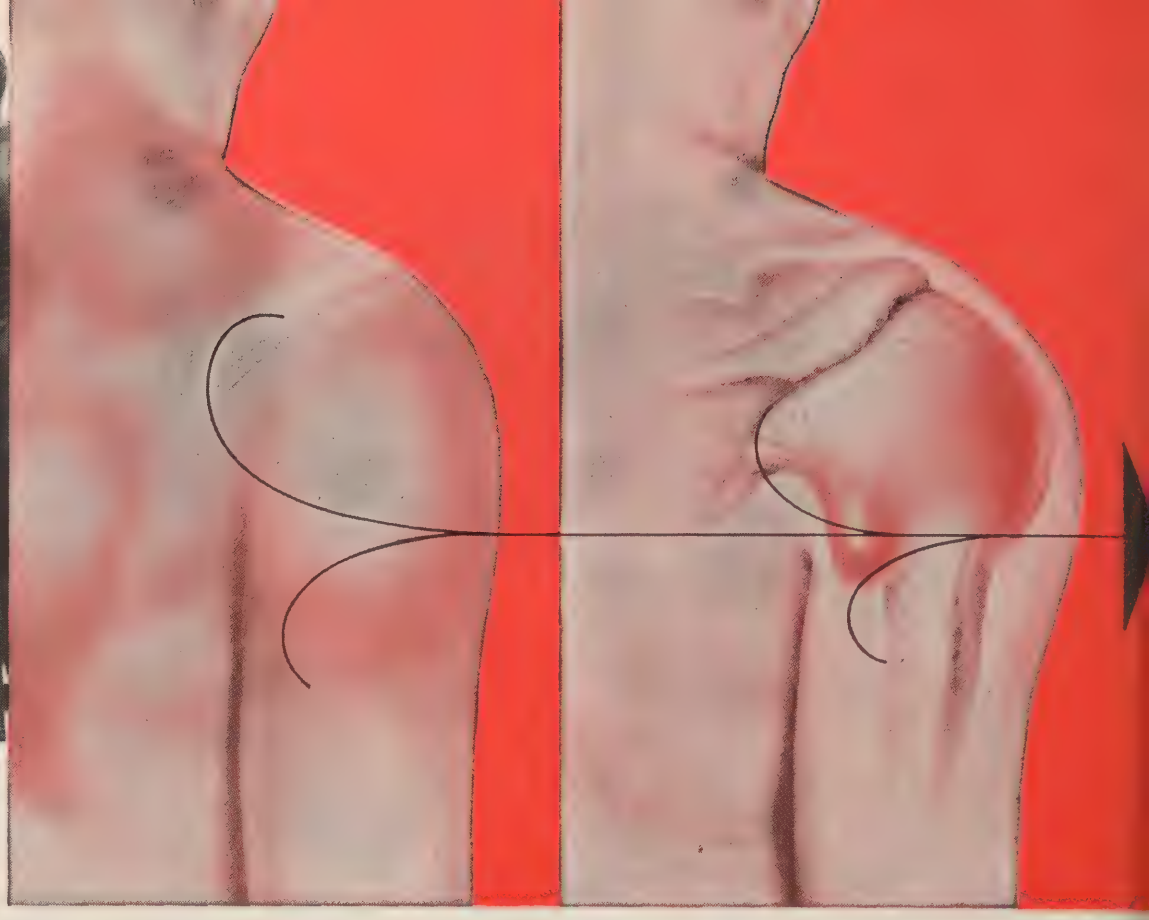
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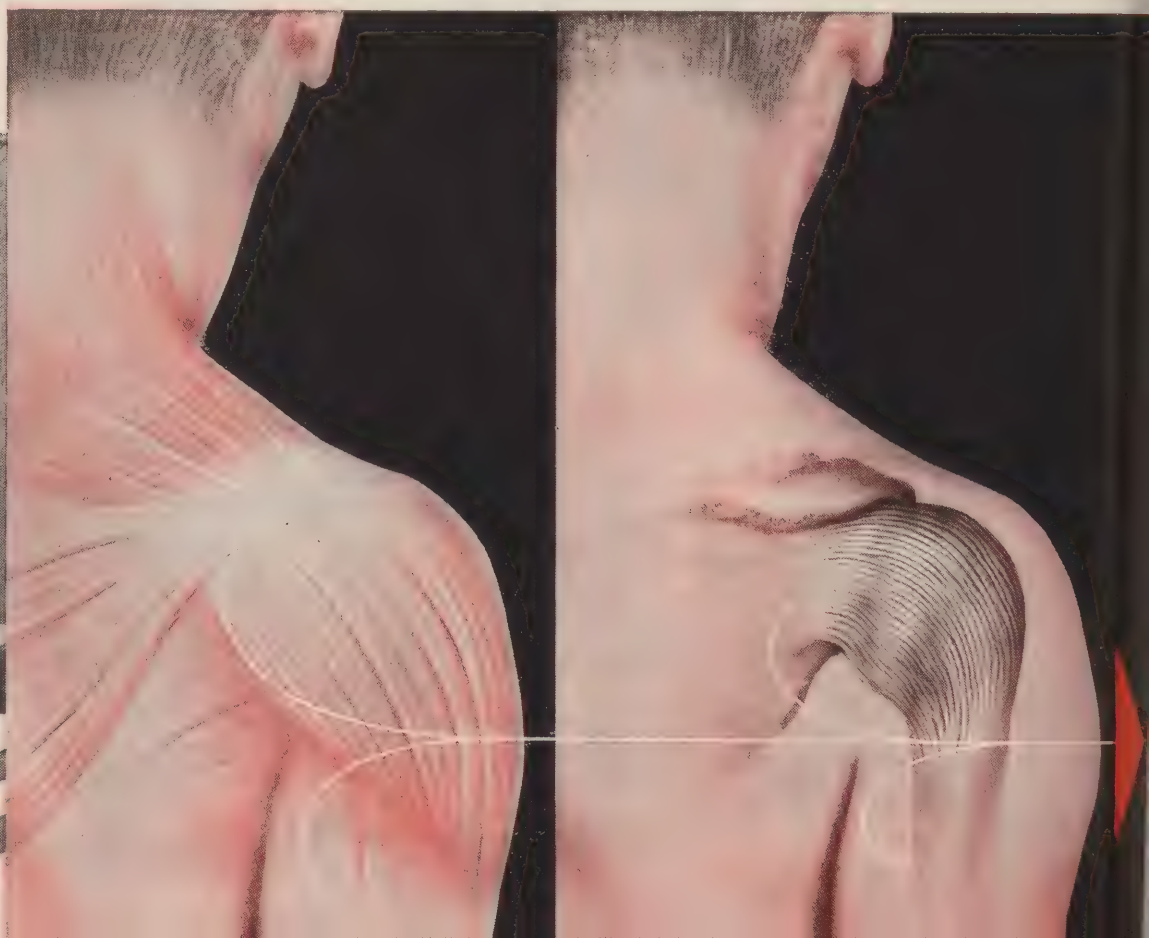
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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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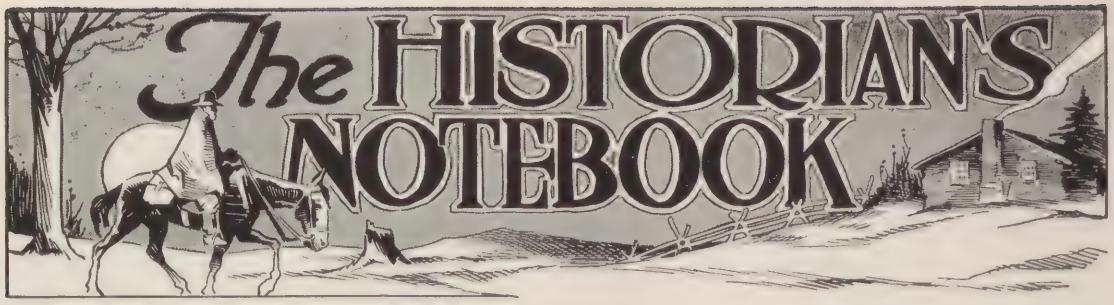
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Biological Economics

MARTIN FISCHER, M. D.

PART I

THE association between biology and economics is well illustrated when reference is made to one of today's many problems—that of the decreasing number of *work* hours demanded each week of the self-sustaining inhabitant, with the consequent increasing number of *leisure* hours thus granted him.

Within this week (middle July 1957) Walter Reuther has started his plug for the four-day working week. In addition, four hours of labor are to be paid for as though they were five. There is not the slightest doubt but that he will accomplish his ends. But will they be those anticipated? I expect to convince you that that will not be the case and that man's salvation does not lie over this path. But before doing so, let me tell you that Reuther, himself, is not sure. To investigate the matter he has appointed a "committee." That's error number one, for committees never bring forth anything above the level of the mediocre—unless it be something worse. Recall that it was a committee which judged Socrates wrong and passed him the hemlock cup. The new and the better always spring from an individual.

Reuther is going to bring us more leisure. But what purpose that, when what we have already is too much?

The State of Leisure

The advantages of leisure have been favorably touted many times. Look how happy Grandpa is who in his retirement has gained more hours free for rocking a cradle; or look at Ma who in her vacation with pay is enabled to get sunburned more quickly and thus sooner lay a foundation for skin cancer; or look at brother Josh who craves leisure in which to upset the beautiful balance of nature by killing everything that flies, roams or swims.

Could it be that leisure kicks back and sometimes actually backfires? That seems to be the law which Cutten put so well in his book of the 'twenties when he gave it the title: *The Threat of Leisure.** Fifty years ago nobody believed that leisure could possibly carry a threat. Yet here it is! Recall the history of the word itself. Leisure originally meant *an opportunity to do something;* it has come to mean *an opportunity to do nothing.*

And therein lies the danger both to the individual and to society.

Celebrating Darwin

1957 has been designated the Darwin Year and we celebrate the man who gave us the concepts of biological evolution, the origin of species and the survival of the fit.

In that connection recall my talk to you of two years ago when I questioned the mechanisms proposed for evolution, asking you to substitute for them those of Lamarck who some 50 years earlier had dealt correctly to my mind, with each of the elements before us—with evolution and its too little discussed worse half, devolution; with acquirement and atrophy, and the primal cause

The Author

● **Dr. Fischer, Cincinnati, is emeritus professor of physiology, University of Cincinnati College of Medicine.**

Read before the Kiwanis Club, Covington, Kentucky, July 17, 1957.

*Cutten, George Barton: The Threat of Leisure. New Haven, Yale University Press, 1926.

of each; with the inheritance of what made master or serf. Lamarck declared, in brief, these three great principles:

(1) Form is the product of function; and not the other way about. (I interpolate in illustration Aaron Burr's advice to his daughter, Theodosia: "Cultivate a benignant expression; in six months it will be yours.")

(2) Through use, every physiological attribute is strengthened and the longer so employed, increased (recall the right arm of the blacksmith); even as through non-use, it is weakened and decreased perhaps to the point of its disappearance (recall the shrinkage of the "second stomach" of the herbivorous to the appendix of the carnivorous).

(3) What one generation thus gains or loses, it passes on to the progeny.

Redfield's Lamarckism

More recent proof of the truth of Lamarck's laws has come through Casper L. Redfield (1900). Trotting horses acquire the faster gait only as they are raced; milch cows give more gallons of milk only as they are milked; hunting dogs continue hunters only as long as used in the chase and not turned into lap dogs; and men of great skill or great mind will so continue only as the virtues born into them are kept at work.

Development comes through resistance; it comes through overcoming and that means work. Atrophy comes from opposite direction and characterizes him who lies down on the job. These are biological laws which cannot be flouted. As a favorite evangelist of mine used to say: "You cannot cheat God." Thus is forecast the failure that will come to Reuther and all his kind, for the better day for mankind lies not in lessened but in increased labor.

The Line Drawn

How much more of labor victory, increase in income and increase in the number of his non-working days can the subject stand before he kills not the overlord but himself?

As of now, the picture of the college graduate going into action is not a particularly stirring one. According to a survey by Louis Kraar and James N. Wallace (staff reporters of *The Wall Street Journal*, Friday, June 14, 1957) these men find the graduating class of 1957 in its own words, "silent, satisfied, fired by few political or economic challenges." They want above all social security and none of the romance of risk. They expect to live above the middle of the social classes but they do not believe that this will call for much work on their part. They are not ambitious to conquer the tough job nor yet to fall into one which demands responsibility. All this leads up to the effortless life, and so to the atrophy of any man's inborn faculties. When indeed, ambition is declared, it is framed in these words of a senior collegian. The English is his not mine.

Personal Avowal

"Ten years from now," says he, "I'd still like to be so nobody can tell me what to do. I want plenty of liquor, women and a big bank account, a nice car to drive. I'll have a bachelor's apartment with a hi-fi set, a den and a bar. My real hopes are to really make a bundle. I figure you've got to have it to have any fun. I want the best liquors and a nice girl who won't worry me about marrying her. I don't visualize the picket fence type of living; that's sheer boredom."

Whither?

Now don't fall off your chairs as I try to indicate to you the only route that mankind must travel to save itself.

It is that of the doctor!

This is not to debase the qualifications or the aims of any other pilgrim seeking right answer, but the man of medicine has tremendous advantage. He has not sought his high place but has been pushed into it. This is because mankind has, since time began, built up for itself a concept of the physician as a demigod, unbiased as to color, creed, politics or social status. Man throughout the centuries, in all climes, under all flags and with all colors has held the figure of the doctor the one most helpful, the one least grasping and the one most to be trusted. The cleric, the lawyer, the good citizen can do no more and they are esteemed in the order in which they serve the total of mankind.

(To Be Concluded in July Issue)

Historian Dies

John O. Marsh, Columbus, who contributed directly and indirectly to the Historian's Notebook, died at the age of 52 on April 7. A former curator of history for the Ohio State Archeological and Historical Society, now the Ohio Historical Society, he more recently held the post of naturalization instructor for the Columbus Board of Education. He was also secretary-treasurer of the Ohio Academy of Medical History.

In the earlier days of this Nation, the use of snuff as a dentifrice was quite popular. Pulverized tobacco sweetly scented and flavored with powdered rose petals, lemon, verbena, grated prunes, cheese, rose-scented vinegar, and extracts of vanilla and peppermint, cognac or sherry wine, were used.

AN AMES CLINIQUICK[T.M.]
CLINICAL BRIEFS FOR MODERN PRACTICE

Which plasma proteins may be hazardous in renal disease?



The globulins. They are more easily precipitated to form casts with blockage of renal tubules. The greater the damage to the glomeruli, the greater the proportion of urinary globulin to albumin and subsequent tubular impairment.

Source—Hoffman, W. S.: The Biochemistry of Clinical Medicine, Chicago, The Year Book Publishers, Inc., 1954, p. 233.

colorimetric "dip-and-read" test for proteinuria

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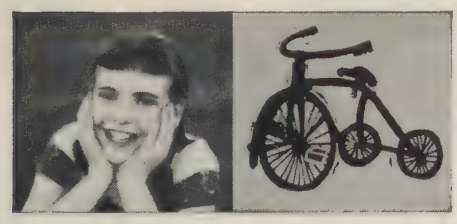
in each of these indications for a tranquilizer...



SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.



Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.



Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.



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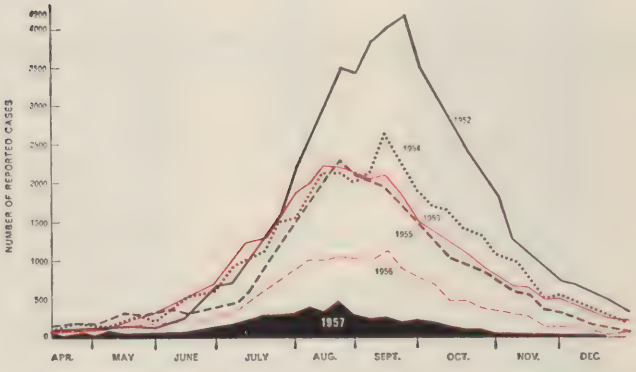
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A MIRACLE IN OUR TIME?

At the last accounting,[1] physicians throughout the country had administered at least one dose of poliomyelitis vaccine to 64 million Americans—all three doses to an estimated 34 million. Undoubtedly, these inoculations have played a major part in the dramatic reduction of paralytic poliomyelitis in this country.



Incidence of polio in the United States, 1952-1957
(data compiled from U.S.P.H.S. reports)



vaccine is plentiful for the job remaining

There are still more than 45 million Americans under forty who have received no vaccine at all and many more who have taken only one or two doses.

As it was phrased in a public statement by the Department of Health, Education, and Welfare:

> *"It will be a tragedy if, simply because of public apathy, vaccine which might prevent paralysis or even death lies on the shelf unused."*[2]

Eli Lilly and Company is prepared to assist you and your local medical society to reach those individuals who still lack full protection. *For information see your Lilly representative.*

1. J. A. M. A., 165:21 *(November 23), 1957.*

2. Department of Health, Education, and Welfare: News Release, October 10, 1957.

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The Ohio State Medical Journal

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Vol. 54 June, 1958 No. 6

JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

Resuscitation

JAY JACOBY, M. D., CAROLYN ZIEGLER, M. D., WILLIAM HAMELBERG, M. D., and JOHN JONES, M. D.

ARE Boy Scouts better able to deal with an emergency than physicians? With the advent of warm weather, increasing numbers of respiratory emergencies can be expected, due to swimming accidents. When a doctor arrives on the scene, is he as well qualified to resuscitate the patient as Boy Scouts, police, firemen, or Red Cross workers? In many instances, the physician is at a disadvantage, since the techniques of artificial respiration have been practiced by the others, whereas the physician has only a vague reading knowledge of the subject.

Many people believe that in an emergency, something—a respiratory or cardiac stimulant—should be injected. To do any good at all, drugs must be given intravenously; absorption from intramuscular or subcutaneous sites would be too slow. If respiration has stopped, drugs are of no value until a clear air passage and adequate artificial respiration are established.

Even if the physician becomes an expert with manual artificial respiration, he is still only equal in ability to a trained layman. The manual methods of artificial respiration, at best, are not very efficient or effective. This article will describe techniques whereby the physician can excell in this vital task.

Every physician should be experienced in the use of resuscitation equipment, as well as in the methods of artificial respiration which may be used in the absence of such equipment. The technique now recommended by the American Red Cross and other official agencies is the arm-lift back-pressure method (Holger-Nielsen). This is more efficient than the other techniques which were formerly popular (Schaeffer, Eve, etc.). Motion pictures demonstrating the approved techniques are available for showing at county medical societies and hospital staff meetings (Squibb & Sons and U. S. Coast Guard, Division of Visual Education).

The need to perform artificial respiration arises in many situations, aside from those connected with swimming or other accidents. Acute disturbances of the respiratory system may develop in otherwise healthy individuals. Effective and promptly executed resuscitative measures may save a life which would otherwise be needlessly lost. The following case reports are examples of the difficulties which may arise in the physician's office.

Case Reports

Case I: A 49 year old white male who early in life sustained a lye burn of his esophagus, came to the out-

The Authors

- **Dr. Jacoby, Columbus, is Professor and Director of the Department of Anesthesiology, Ohio State University.**
- **Dr. Ziegler, Columbus, is Assistant Director, Department of Anesthesia, University Hospital.**
- **Dr. Hamelberg, Columbus, is Assistant Professor, Department of Surgery (Anesthesia), Ohio State University College of Medicine.**
- **Dr. Jones, Columbus, is Instructor, Department of Surgery (Anesthesia), Ohio State University College of Medicine.**

patient clinic for dilatation of his esophageal stricture. This was not a new experience for him. His esophagus had been dilated about 200 times under local anesthesia. Premedication of 120 mg. phenobarbital, 100 mg. Demerol®, and 0.4 mg. scopolamine was used. His throat was sprayed with approximately 5 cc. of 20 per cent cocaine.

After anesthesia developed, he was escorted into the treatment room. In transit, he began to complain of feeling dizzy and had to be helped to the table. He then lost consciousness and began to convulse. He was given 120 mg. of Nembutal® intravenously. This was followed by 2 cc. of Coramine® intramuscularly (contraindicated). For the next five minutes the patient became progressively cyanotic, and the convulsions became more sustained. His pulse was not palpable. At this time, an anesthesiologist arrived. He inserted an airway and gave artificial respiration with oxygen by mask. This relieved the cyanosis.

Associated with this man's convulsions and respiratory difficulty, he also had circulatory depression. The pulse and blood pressure were restored with an infusion containing 5 mg. Neo-Synephrine® in a liter of 5 per cent dextrose solution. To combat the cerebral edema which would probably occur as a result of his cyanosis and convulsions, he was given 100 cc. of concentrated serum albumin intravenously. He was admitted to the hospital and followed closely thereafter. Consciousness returned four hours after the episode. He made an uneventful recovery.

Case II: A 55 year old man was treated in a doctor's office for a boil on the thigh. In order to relieve the pain, and to facilitate incision of the boil, the physician thought it would be wise to give the patient an opiate. Accordingly, he told his office assistant to prepare an eighth of a grain of morphine, and he administered it to the patient intravenously. Within the next three minutes, the patient developed progressive drowsiness. He finally became comatose and stopped breathing.

The doctor instructed his office assistant to call for the Fire Department Emergency Squad. In the interval, he administered artificial respiration manually, but progressive cyanosis developed. The prompt arrival of the Emergency Squad and their effective use of resuscitation equipment was responsible for the satisfactory outcome of the case. A narcotic antagonist (Lorfan® or Nalline®) might have been effective if given early.

Later questioning of the office assistant established the fact that she had found only quarter grain tablets of morphine in the cabinet. Instead of dividing the quarter grain (15 mg.) of morphine in half, she used two tablets, thinking that one-fourth and one-fourth equal one-eighth. The resulting mixture therefore contained a half grain of morphine (30 mg.).

Case III: A 31 year old woman, without previous history of allergy, was given 200,000 units of penicillin by her physician. Shortly after the injection the patient developed nausea and her skin became bright red and flushed. This was followed by severe dyspnea and projectile vomiting. The patient then became unconscious and cyanotic, and she had no palpable pulse.

The physician administered Adrenalin® intramuscularly without result. Oxygen was given by nasal catheter and the cyanosis was partially relieved. An infusion containing Neo-Synephrine was started, and the patient was transferred to a nearby hospital.

Oxygen and vasopressors were needed for the next 12 hours. The patient regained consciousness about six hours after the episode and made a complete recovery. About a year later, the patient took some penicillin orally and a similar incident occurred.

Clear Airway

The goal in artificial respiration is to accomplish pulmonary ventilation, thus getting oxygen into the lungs and carbon dioxide out of them. The various methods of manual artificial respiration function largely by compression of the chest, forcing air out of the lungs; when the pressure is released, the elasticity of the thoracic cage tends to restore it to its original shape and volume. This creates a slight vacuum within the thorax and draws air into the lungs.

In all types of artificial respiration, clear air passages must be maintained so that air or oxygen may freely pass into and out of the lungs in response to small pressure changes. If the breathing passages are obstructed, even slightly, little or no air will be moved; the pressure changes are so small that they cannot overcome even moderate resistance.

To provide a clear air passage, the physician inserts his finger into the patient's mouth and removes any foreign material which may be in the mouth or pharynx. Secretions or blood are removed by the physician's finger wrapped in a gauze or a handkerchief or by suction, if available. This having been done, the patient's head is extended and his chin is held up. To support the chin, the physician's fingers are loosely clenched into a fist. His index fingers are then inserted behind the angles of the patient's mandible. The physician's thumbs rest along the sides of the mandible holding the mouth slightly open. The mandible is pushed forward so that the patient's lower teeth override his upper teeth. This provides a clear air passage in the great majority of patients. In addition, an oral airway may be inserted, or the tongue may be grasped with gauze or handkerchief, and pulled forward.

The insertion of an endotracheal tube or the performance of a tracheotomy are far more certain methods of obtaining a clear airway. Many fatalities could be avoided if these two procedures were used earlier and more frequently.

Manual artificial respiration is often ineffective because insufficient attention is paid to maintaining a clear airway. One person often cannot adequately manage the airway and at the same time perform the manipulations involved in the usual methods of artificial respiration. The physician should manage the airway, and have the trained layman perform the maneuvers of the arm-lift back pressure method.

Artificial Respiration Without Equipment

The physician, however, can and should obtain better results with artificial respiration, than a layman using the standard methods. Mechanical resuscitators are complicated and expensive. Often, they are not available, or do not function in time of emergency, because they were not properly cared

for at the time of previous use or because their method of operation is forgotten.

In the absence of any equipment, the best method of artificial respiration is mouth-to-mouth breathing. This has three advantages over other methods:

(1) A positive pressure is used to force air into the patient. This can overcome mild obstruction.

(2) Each time that air is blown into the patient's mouth, the lungs fill and the chest can be seen to rise. This gives proof of the effectiveness of the treatment.

(3) The same person can maintain a clear airway and also inflate the patient's lungs. The method is neither tiresome nor difficult, and can be maintained for prolonged periods with little effort. A modification of this is mouth-to-tube insufflation.

The physician's exhaled air, which enters the patient's lungs, is slightly lower in oxygen content and slightly higher in carbon dioxide content than ordinary air. The difference in gas content, however, is not sufficient to be of practical importance. Exhaled air contains about 16 per cent oxygen and is ample to support life. Because he is hyperventilating at this time, the physician's exhaled breath contains more oxygen than is ordinarily present. Remember, it is better to ventilate the lungs with exhaled breath containing 16 per cent oxygen, than to try to ventilate them with air containing 21 per cent oxygen, and not accomplish it.

Technique

Mouth-to-mouth resuscitation is accomplished in the following way:

(1) Be sure there is no foreign material in the patient's throat.

(2) With the patient lying on his back, his head is extended.

(3) The physician places himself above the head of the patient so that he is facing the patient's feet. The physician makes himself comfortable in this position, allowing his elbows to rest on the ground so that there is no physical strain.

(4) The patient's mandible is supported.

(5) The physician places his mouth over the patient's mouth, with his lips slightly separated and pressed closely upon those of the patient. The tighter the fit between patient and physician, the more effective is the effort to force air into the patient's lungs. If the fit is too loose, most of the air will blow out along the sides and little will enter the patient's lungs.

(6) The physician blows his exhaled breath into the patient's mouth at whatever rate is comfortable for him. Because of excitement, the physician's respiration will be more than adequate in rate and depth to provide for the patient's oxygen requirements.

(7) The physician's lips are lifted slightly each time he inhales, and replaced on the patient each time he exhales.

(8) Mouth-to-mouth respiration should be maintained until the patient recovers adequate spontaneous respiration, or until equipment for artificial respiration is brought to the scene.

Speed of action is far more important than the use of complicated equipment. Never delay artificial respiration in order to bring the patient to the equipment. On the contrary, begin mouth-to-mouth resuscitation immediately; have the equipment brought to the patient.

Simple Equipment for Artificial Respiration

Every physician should have available a device for artificial respiration with oxygen; this is more desirable than any method which uses air. The need for it may arise because of anaphylactoid reactions, local anesthetic reactions, or other reasons. The same equipment can be used for oxygen inhalation and is of value for many patients who have attacks of syncope, angina, or respiratory distress. The equipment need not be complicated, heavy or expensive.

The mouth-to-mouth method can be modified in accordance with the method of Elam, using mouth-to-tube breathing.

A simple portable device, utilizing small cartridges of oxygen has been developed by Dr. Robert Hingson. Called the Western Reserve Midget, it may be purchased from Z & W Machine Products Co., Cleveland, Ohio, and can also be used to administer anesthetics. Each cartridge contains only enough oxygen to fill the breathing bag. If the mask does not fit tightly upon the patient's face, the supply of oxygen is quickly lost, and the cartridges must be replaced with great frequency.

Each physician can prepare a simple but very effective device for artificial respiration from inexpensive components. Basically, the equipment consists of an anesthetist's face mask, a breathing bag, and a metal connection for them. Either the connection or the bag must have a nipple for the attachment of the rubber tube which delivers oxygen. The Kreiselman bellows is also satisfactory.

Oxygen can be obtained from a hospital or drug supply company, or from any industrial welding supplier. Industrial and medical oxygen are equally pure. A large cylinder of oxygen, with reducing valve and flow meter, may be rented and kept in the physician's office. For portability, a small cylinder of oxygen with reducing valve and

flow meter, can be rented or purchased. The small cylinder, about 20 inches in height, contains over 350 liters of oxygen, sufficient for most emergency situations.

In the event of an emergency, the oxygen cylinder is turned on and the flow rate is adjusted so that the breathing bag always contains oxygen. The minimum flow rate is 5 liters per minute (to blow away carbon dioxide); the maximum flow rate is whatever quantity may be necessary to keep the bag filled in spite of leaks between the mask and the patient's face.

The mask is placed over the patient's mouth and nose, settling it to the contours of the face in order to minimize leaks. The physician's left hand supports the patient's chin to maintain a clear airway, and holds the mask tightly to the face. With his right hand, he grasps the bag of oxygen and squeezes it intermittently, to force the oxygen into the patient's lungs. When he performs artificial respiration effectively, the physician is rewarded by seeing the patient's chest rise as the lungs fill with oxygen. Unless the patient's chest expands, something is wrong; either the airway is obstructed, or not enough oxygen is being forced into the lungs.

There is little reason to fear the effect of excess pressure. The problem is to get enough pressure to inflate the lungs and overcome the leaks. The inflation of the lungs can be regulated by moderating the force of bag squeezing.

Although expensive resuscitation machines are undoubtedly useful, the simple devices mentioned here are equally effective. It is recommended that one of these be kept in every phycician's office and at every swimming pool, and that physicians and lifeguards learn to use it. A set of various sized airways should be kept with it.

Summary

(1) Many occasions arise for physicians to administer artificial respiration, both in their offices and at the scene of accidents such as drowning. (2) Speed is essential, since life can be sustained for only a few moments in the absence of respiration. (3) The most important factor in artificial respiration is a clear air passage. Constant attention is required to keep it clear. (4) Without equipment, the most effective method of artificial respiration is mouth-to-mouth insufflation. (5) The physician can do better artificial respiration than a layman if he: (a) maintains a clear airway; (b) sees that expansion of the chest follows each effort to inflate it. (6) A device for the administration of artificial respiration with oxygen should be kept in every physician's office and at every swimming pool. Physicians and lifeguards should learn to use it.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is a summary of cases presented before the Franklin County Pelvic Cancer Delay Committee on April 16, 1958. The meeting was held at the Columbus City Health Department.

Case No. 58. The patient is a 55 year old white female with the onset of vaginal bleeding approximately 16 months ago. Thirteen months ago she was seen in a cancer clinic but was not examined. Admission to the hospital for evaluation was advised but she refused at that time due to transportation difficulties. Eight months prior to the present time the patient received intracavitary radium and approximately 30 external x-ray treatments. She was then followed with periodic examinations at three month intervals. Six weeks ago she again had the onset of vaginal bleeding, nausea and vomiting consistent with a 10 to 20 pound weight loss. Three days ago this patient was admitted to the hospital with a partial bowel obstruction, and, diagnosis is carcinoma of the cervix, clinical stage IV.

Comments: *Patient delay,* three months. *Institutional delay,* five months. It is most important for a patient to be seen by a physician rather than a social worker or a nurse and this patient delay could have been avoided with proper management in the clinic. Patient had full therapy but too late.

Case No. 59. The second patient presented today is a 63 year old white female who had her first symptoms of bleeding in July. She first consulted her family doctor in October and was referred to a general surgeon who advised against surgery but referred the patient to a radiologist. She first saw the radiologist in January and he found her to have a stage III carcinoma of the cervix and gave her external therapy during January and early February. She was then referred to a cancer clinic for further care. In April on admission to a hospital she was found to have radiation changes in the skin anteriorly and posteriorly with evidence of a 5 cm. midline lead strip having been used. She had an exophytic necrotic bleeding tumor mass involving the entire cervix and extending two thirds of the way down the vaginal wall. It extended laterally to the left pelvic wall and two thirds of the way to the right pelvic wall. She is now being evaluated for central therapy with radioactive cobalt.

Comments: *Patient delay,* four months. *Physician delay,* seven months. General surgeon could and should have done a biopsy or at least a Papanicolaou smear examination. Patient received insufficient x-ray therapy.

Case No. 60. This is a 51 year old white female with history of bleeding from January to March. She saw her physician who recommended immediate biopsy and report reads squamous cell carcinoma of the cervix, clinical stage III. The tumor was a cauliflower-type growth replacing the entire cervix and extending two thirds of the way down the anterior vaginal wall. There is invasion of the posterior fornix.

Comments: *Patient delay,* two months. *Physician delay,* none. In many instances the amount of delay may be due to patient's lack of responsibility, unawareness or inability to accept diagnosis. This could have been picked up earlier on routine examination.

Topical Treatment of Psychosomatic Skin Reactions

J. SHANON, M. D.

THE term "psychosomatic" as aptly defined by Alexander[1] means "a method of approach both in research and in therapy, namely the simultaneous and coordinated use of somatic and psychological methods and concepts."

We find, in dermatologic practice, that many patients have skin conditions which are caused or aggravated by chronic emotional conflicts. In these cases, it is necessary to provide, contemporaneously, psychotherapy (relationship, supportive, suppressive, expressive) and local treatment.

The choice of topical therapy is of the highest importance, since it might improve or aggravate the skin condition. Sometimes, especially at the beginning of the therapy, the effect or lack of effect of a local application is crucial in determining the doctor-patient relationship which is of primary importance in the course of treatment. This is of particular importance in the treatment of patients with psychosomatic skin diseases.

Ideally, a topical preparation should not sensitize or irritate the skin. In addition, it should have soothing and cleansing qualities. Such qualities are possessed by a colloidal oatmeal* preparation, (Aveeno®[3], which was chosen to be used as local treatment for patients with psychosomatic skin diseases who were receiving a tranquilizer (Trilafon®) and/or psychotherapy.

The purpose of this study was to determine if the colloidal oatmeal preparation contributes to the efficacy of tranquilizers and/or psychotherapy in the treatment of patients with psychosomatic skin diseases.

Material and Methods

Aveeno is a colloidal oatmeal preparation which contains 46 per cent oat starch, 24 per cent oat protein and 9 per cent oat oil. It is a dry, palpable powder, dispersible in warm and cold water. When dispersed in warm water, Aveeno absorbs a large amount of water, developing a good covering power. It is recognized for its relative lack of irritating and sensitizing factors.

Its skin coating ability and its mildly acid *p*H counteracts the alkalinity of diseased skin. Unlike soap it does not remove the protective lipid mantle which guards the normal acid *p*H of the skin.[2, 3] Thirty-one patients with pronounced psychosomatic dermatoses who ranged in age from 4 to 82 years including 21 females and 10 males were studied for a period of 5 to 10 weeks, during which time they were treated with local applications of colloidal oatmeal. Of these 31 patients 9 patients were on a psychosomatic ward. The remainder were studied on a dermatology service. The colloidal oatmeal was administered by means of a bath (19 cases) or shower (12 cases). Table 1 indicates the disease entities and mode of local treatment.

*Colloidal oatmeal used in this study was Aveeno®, furnished by Aveeno Corporation, New York 19, N. Y.

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TABLE 1—*Types of Dermatoses Treated with Colloidal Oatmeal*

Diagnosis	No. Patients	Bath	Shower
Atopic Dermatitis	6	3	3
Neurodermatitis	4	2	2
Duhring's Disease	1	1	0
Hand Dermatitis	4	4	0
Lichen Planus	2	1	1
Seborrhoic Dermatitis	4	2	2
Psoriasis	5	3	2
Chronic Urticaria	3	1	2
Pruritus Vulvae and Ani	2	2	0
	31	19	12

Mode of Preparation

Bath: Two cups of cold water were added to one cup of colloidal oatmeal. The powder was rubbed into a paste which was then placed in the tub beneath the faucet. Warm water was allowed to flow at full force over the paste. Such a preparation of the bath avoided the forming of lumps. The tub contained about 25 gallons of water which was brought to the temperature of 35° centigrade.[3]

Shower: The patients were instructed to wet the part of the body to be cleansed. The colloidal oatmeal paste, made as indicated above, was applied on the affected parts of the body with a light massaging action. They were told to shower lightly for about 10 minutes, allowing the colloidal demulcent to remain on the body.

The use of soap was avoided in all the patients.

Results

Of the 19 patients utilizing colloidal oatmeal baths, a total of 11 showed marked improvement

of itching and of the skin condition. Five of the 19 patients complained of dryness of the skin and as a result were switched to oatmeal shower treatment. On this regimen, three of the five patients obtained subjective and objective improvement, but the remaining two patients demonstrated no change in their skin diseases.

It should be mentioned that there were three patients who discontinued treatment with the colloidal oatmeal baths. Two of these three cases were subjects who suffered a hand washing compulsive neurosis. Both these subjects discontinued therapy, complaining that the baths provided insufficient lather to perform a thorough handwashing.

From the group of 12 patients who were on a colloidal oatmeal shower regimen, 10 showed marked and prolonged improvement of the itching and of the skin condition. Two others experienced a moderate improvement. All 12 patients praised oatmeal showers, which rendered the skin "very clean and beautiful" (a typical statement). All of them experienced relief of emotional tension.

Table 2 summarizes the experimental results.

TABLE 2—*Results of Treatment with Colloidal Oatmeal Preparations*

	No. Patients	Improvement			Discontinued
		Marked	Moderate	None	
Bath	19	11	0	5	3
Shower	12	10	2	0	0
	31	21	2	5	3

Summary and Conclusions

A colloidal oatmeal preparation for local use which is soothing and cleansing, but not irritating to the skin is effective as an adjuvant therapy in psychosomatic skin diseases being treated by a tranquilizer and/or psychotherapy.

Colloidal oatmeal has a favorable influence on the skin and the emotions of the patient, allowing the patient to become more amenable to other means of therapy.

In a variety of nine disease entities, approximately 74 per cent (23 of 31 cases) demonstrated marked or moderate improvement while being treated with colloidal oatmeal baths or showers. It appears that the best results were obtained with colloidal oatmeal showers. This method of therapy is easy to apply and it appears to be most pleasant to the patient as well as being most effective in ameliorating the skin pathology.

Colloidal oatmeal is also indicated in skin patients who are on a research program where there is a need to evaluate the effect of a medical, psychiatric or combined therapy, since it does not interfere with other modes of treatment.

For all these reasons colloidal oatmeal appears to be an excellent topical application for the psychosomatic skin patient.

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Selective Readings

Radiation: What It Is and How It Affects You, by Jack Schubert, Ph. D., and Ralph E. Lapp, Ph. D. (*$3.95. Viking Press, New York 22, N. Y.*) By some strange circumstance this book was published about the time that Albert Schweitzer made his world-wide appeal for the abolition of nuclear weapon tests; a few days before the opening of a special Congressional inquiry into present and future fall-out perils and coincided with the 1957 United States and British nuclear explosions which provoked riots in Japan.

Those familiar with Dr. Lapp's writings on this subject find it no surprise that he and Dr. Schubert have followed the Liberal-Neutralist communist line for the moment and recommended an immediate world-wide ban on atomic nuclear tests. This book is of particular interest, however, to us physicians since a great deal of emphasis is put upon the consideration of the perils of the overuse and the misuse of radium, radioisotopes, x-ray and fluoroscopes in medical diagnosis and treatment. How careless operators of x-ray equipment are in handling this lethal machine was shown in the 1954 survey of 82,000 American physicians; the average radiologist lives 5.7 fewer years than the average doctor who is not exposed to radiation and most of us are operating machines without any calibration of the amount of radiation they deliver and we have an increasing number of people who expect an x-ray picture to be taken whenever anything is wrong with them.

The whole question of radiation is extremely controversial and it is impossible to get at the facts at the present time because scientists are divided into two definite groups so far as personal bias is concerned. The majority do not see any harm in radiation as long as nobody is killed or mutilated. The minority think that we should establish the harmless character of this agent before we use it promiscuously and that it is up to the ones who are going to use it to prove that it is not harmful. Geneticists are frightened about what is going to happen to future generations.

So-Called Tranquilizing Agents

DR. ROBERT C. KIRK

SIR WILLIAM OSLER once wrote "The desire to take medicine is perhaps the greatest feature which distinguishes man from animals." The desire to write about their effects might distinguish physicians from laymen. The bibliography for a recent drug, Aureomycin,® has passed 10,000 items and that for Thorazine® has passed 5,000. It is hard to believe that any author has carefully reviewed the literature on either drug, nor does the present one intend to. However, nearly 25 years of attendance on sick adults has given him some opinions on drug usage and drug effect, especially as they apply to the "nervous patient." These he intends to use freely in discussing tranquilizing agents. Psychotropic drugs or ataractics, or apathecatory agents are other ways of labelling such substances. It is well to keep in mind the definition of ataraxy; freedom from confusion or anxiety. But it also has been defined as "stoic indifference." Is this the *nirvana* of the ancients? It is well for us to try to have a clear answer to this.

Never before in the field of emotional conflict have so many chemicals been administered to so many patients with so many diverse results. Opinions have ranged from "no benefit" to such enthusiasm in one symposium as to have a reporter liken it to a revival meeting. One is reminded of another saying, "Beauty is in the eye of the beholder."

Structural Relationships

The major breakthrough in the treatment of severe mental disease with drugs, occurred a little over four years ago with the discovery of chlorpromazine, known in this country as Thorazine, where it has been taken by an estimated 9-million patients. Chemically it is related to phenothiazine,[1] the most widely used anthelmintic in veterinary medicine. From it were made the two antihistaminics Phenergan® and Pyrrolazote® and the two anti-parkinsonism drugs, Parsidol® and Diparcol.® Similar to Thorazine in structure and possibly in action are other less widely used tranquilizers, Trilafon,® Pacatal,® Sparine® and Compazine®. Of these I have little knowledge.

Mode of Action

In the classifications of psychotropic drugs, the phenothiazines and reserpines are considered true tranquilizers. This they are thought to do by relieving the primary unconscious, subcortical epinephrine precipitable warning and tension-anxiety manifestations. Walton[2] says they affect the midbrain and cut down sympathetic effect. This is simpler and strikes me as much more measurable. They are said to antagonize acetylcholine, histamine and serotonin. Gerard[3] wrote recently, "I doubt if anybody knows enough about any drug to have more than a private opinion as to the directions and significance of his laboratory explorations."

Results of Treatment

Much better known are the results in series of treated patients. Thorazine suppresses psychomotor activity and calms to a state of docile tractability. This has resulted in recovery sufficient to permit the return home of over 80 per cent of patients with acute schizophrenia. It has improved the figures for chronic schizophrenics from 19 per cent to 34 per cent going home. It has acted impressively in acute alcoholism providing severe hypotensive crises are avoided by the proper use of Levophed® when necessary. It has practically abolished lobotomy and has reduced electroshock treatments in the great psychiatric hospital of St. Elizabeth's, from 1168 to 107 in one year. It has become a standby in the treatment of hiccoughs and of vomiting.

Its use in anxiety states has been extremely disappointing in my own practice. An occasional spectacular result could as well be explained by a "placebo-reactor" effect. By and large no patient of mine has requested continuation of treatment with Thorazine. It has deepened depression alarmingly in at least two cases, requiring institutionalization for many weeks.

Every physician prescribing phenothiazine derivates should know the relative frequency and type of adverse effect which he may expect. The

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following, taken from Hollister's[4] current article refers primarily to the best studied drug, Thorazine.

Adverse Behavioral Effects

1. Both Thorazine and reserpine may cause a worsening of abnormal behavior or primarily produce abnormal behavior, especially reserpine. Such symptoms are restlessness, insomnia, bizarre dreams and social withdrawal. Depression resulting in suicidal attempts has been the most serious effect.

Toxic Effects on the Central Nervous System

1. The Parkinson syndrome may appear in patients receiving 300 mg. or more of Thorazine or 2 mg. of reserpine daily.
2. Seizures.
3. Dystonic syndrome.
4. Hyperthermia or hypothermia.
5. Myasthenia-gravis-like syndrome.

Toxic Effects on the Autonomic Nervous System

1. Hypotensive crises.
2. Nasal congestion.

Chlorpromazine:
- Tachycardia
- Dry mouth
- Blurred vision
- Pallor
- Constipation or impaction

Reserpine:
- Activation of peptic ulcer
- Bradycardia
- Excessive salivation
- Cutaneous flushing
- Vomiting
- Diarrhea

Allergic or Toxic Reactions Chlorpromazine Only

1. Jaundice, 1 to 2 per cent of patients treated over seven days. May persist six months.
2. Agranulocytosis—50 cases.
3. Purpura—rare.
4. Dermatitis—common (nurses, especially).

Metabolic or Endocrine Effects

1. Weight gain, as high as 60 pounds.
2. Lactation—12 per cent in women
3. Gynecomastia
4. Menstrual irregularity.

With these undesirable side effects and reactions kept carefully in mind there is no reason why any physician may not feel free to treat any patient he considers a subject for such therapy. As Hollister[4] points out, therapeutic paralysis has never done patients much good. On the other hand, it is not for the drug houses to tell us physicians how and whom to treat. The ultimate decision for this must rest in our consulting room and we neither can nor should avoid the full responsibility for any therapeutic procedure.

Philosophical Considerations

Accordingly it seems proper here to review some thoughts on tension which seem to be at the root of the present-day widespread interest in tranquilizing agents. Aldous Huxley[5] has written a superb article which should be read in its entirety but I quote from his discussion of tension:

"Tension, I should say, arises in persons who, because of some congenital or acquired weakness, are unable to cope with certain distressing situations. These distressing situations are produced by conflict—conflict between the fundamental drives to self-affirmation and sex on the one hand, and the equally fundamental drive to gregariousness on the other.

"Like all other diseases, tension tends to narrow the patient's awareness until, in extreme cases, he is conscious of nothing but himself. Grave illnesses profoundly change the personality of their victims. To this changed personality the narrowing of awareness induced by the illness soon comes to seem almost normal and is taken for granted. Tension is not a severe illness, and those who suffer from tension are well enough to feel and suffer from the cramping self-centeredness imposed upon them by their psychosomatic disorder.

"One of the most disagreeable symptoms of tension is simply the normal distress at being an island universe raised, so to speak, to a higher power. Man is a self-adoring egotist, but an egotist who often feels an intense distaste for the object of his idolatrous worship.

"Correlated with this distaste for the beloved self, there exists in all human beings an urge to self-transcendence, a wish to escape from the prison of personality, a longing to become something other and greater than the all-too-familiar Me, a susceptibility to nostalgia for a world superior to, or at least different from the boring or painful universe of everyday reality. The religious man has attributed this universal urge to self-transcendence to an innate and deep-seated yearning for the divine. The biologist sees the matter somewhat differently, and he attributes man's desire for self-transcendence to the workings of his innate gregariousness. The individual longs to be merged with the herd, but he is too self-centered to be able to do so completely and too self-conscious to be able to sustain the attempt

for long. He is therefore condemned to live in a state of chronic dissatisfaction, constantly pining for something that, in the very nature of things, he can never have."

Of pharmacology he is equally articulate. He writes further: "Let us always remember that, while modern pharmacology has given us a host of new synthetics, it has made no basic discoveries in the field of natural drugs; it has merely improved the methods of extraction, purification and combination. All the naturally occurring sedatives, narcotics, euphorics, hallucinogens, and excitants were discovered thousands of years ago, before the dawn of civilization. This surely is one of the strangest facts in that long catalogue of improbabilities known as human history. It is evident that primitive man, experimented with every root, twig, leaf and flower, every seed, nut, berry and fungus in his environment.

"Pharmacology is older than agriculture. There is good reason to believe that even in paleolithic times, while he was still a hunter and a food-gatherer, man killed his animal and human enemies with poisoned arrows. By the late Stone Age he was systematically poisoning himself. The presence of poppy heads in the kitchen middens of the Swiss Lake Dwellers shows how early in his history man discovered the techniques of self-transcendence through drugs. There were dope addicts long before there were farmers."

With these remarks I am in complete accord, as are the great majority of physicians dealing with such problems. Harry Beckman[6] at Marquette, writes as follows, with a finality that destroys all argument:

"We need a therapy that will attack the etiological factors in mental illness, not merely behavioral disturbances such as those of the unconforming, embattled individual, disturbances that may be manifestations of genius. We must not be satisfied with drugs that merely reduce disturbed persons to a tranquil state. Such agents, applied indiscriminately, may ultimately eliminate from the race those periods of travail, turmoil, and stress out of which the supreme efforts of mankind have so often emerged.

"The potentiality of mental illness exists in all of us (or rather the best of us), and those urges that keep us frothing in our laboratories and at our desks when more sensible men are out fishing are perhaps the precious links with the 'looney bin' that should not be severed. Evidences of imbalance, the symptoms of mental illness, are not the legitimate objectives of exclusive therapeutic endeavor, and the employment of tranquilizing agents on this level alone is loaded with potential doom for the race as the highest of evolved creatures. The etiological factors of overt mental illness are the only safe and proper objectives for treatment."

Conclusion

Except as otherwise stated in the text, the use of reserpine and phenothiazine derivatives in the ordinary office practice for psychoneuroses has been vastly disappointing. The author has attempted to show how this may be a blessing in disguise.

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Management of Comatose Patients Requires Special Treatment

Although coma is a symptom complex, it requires special treatment regardless of cause. It represents one of the five stages of unconsciousness. Improvement of an unconscious patient is characterized by changes from a deep to a lighter stage as illustrated by ascending the rungs of the unconsciousness ladder. Evidence of cerebral decompensation requires vigorous therapy to reverse the physiologic trend.

Maintenance of nutrition, fluid balance and body chemistry in a patient suffering with prolonged unconsciousness is best done by nasal tube feedings which permit normal absorption. Popularity of the sitting position for operative procedures requires an increased emphasis on the probability of venous air embolism. Therefore, all patients should be kept lying on the left side for at least fifteen minutes immediately following surgical therapy.

Early diagnosis of thrombosis of the internal carotid artery or of the superior longitudinal sinus is imperative for appropriate surgical therapy, which may be a life saving procedure. Therefore, angiography should be available. Routine use of fluids or blood intravenously is condemned. Indications for blood transfusions have been tabulated. The house staff, who usually must treat the unconscious patient first, should be trained in proper therapeutic and diagnostic procedures.—O. Hugh Fulcher, M. D., and K. L. McCoy, M. D., Washington, D. C.: *Rocky Mountain M. J.*, 55:27, April, 1958.

Rehabilitation of the Injured

ALEXANDER P. AITKEN, M.D.

THERE can be no doubt that medicine, as practiced today, in these United States has no equal throughout the world. The surgical handling of the case of acute trauma has reached a plane never before attained due to the stress laid upon the importance of adequate first aid, the transportation of the injured, and the tremendous strides made in the surgical handling of the various traumatic lesions aided immeasurably by the antibiotic drugs. The more recent developments made in the treatment of open wounds, in the field of plastic, hand and fracture surgery suffice to indicate the progress made in other fields.

Despite the advances made in the immediate care of acute trauma, the end results often fail to live up to expectations. This is largely due to a major defect in modern medicine, the failure on the part of the medical profession to recognize the importance of adequate surgical and medical aftercare. Unfortunately, rehabilitation of the patient does not end with the healing of surgical or medical wounds. Much more must be done for the patient, far more than is now appreciated by the medical profession in general.

What is meant by rehabilitation? For every group interested in this field there appears to be a different concept. To many, particularly the lay public, the term rehabilitation has become synonymous with physical medicine embracing physical, occupational and recreational therapy. To others, it means vocational training; while to still others, the problem is a psychological one to be treated in the field of psychiatry. These specialties, invaluable to restoration, are but adjuncts in a comprehensive concept of rehabilitation. Rehabilitation means the restoration of the patient to self-sufficiency or to gainful employment at his highest attainable skill in the shortest period of time.

Factors Which Influence Physical Restoration

On what, then, does successful rehabilitation depend? It depends primarily upon the extent and severity of the trauma. It depends upon the competence with which the patient is handled at the scene of accident and during his transportation to and within the hospital. Incompetent care in this phase may greatly augment the gravity of the original trauma.

Perhaps the most important factor of all is the competency of the immediate definitive care. Unless a complete and accurate diagnosis is made and anatomical repair accomplished, then function can never return to the injured part despite the efficiency of postoperative care. To insure the maximum restoration of function, physicians must recognize the limitations of their own ability and not hesitate to call in those more competent to handle the acute emergency.

Of equal importance is the adequacy of treatment rendered in the convalescent period. Physicians in general and surgeons in particular must learn the direct effect such treatment has upon the end result. The utilization of the minimum amount of splinting to permit early active use of uninvolved muscles and joints is a factor not generally appreciated and one which should be corrected by competent instruction in medical school, hospital and postgraduate teaching.

Equally important is the use of exercise, not only for the injured part, but for the body as a whole. How many excellent reductions of Colles fracture end disasterously because of a swollen, stiff hand, or frozen shoulder due to lack of early active exercise of these uninvolved parts? How many patients, confined to bed for weeks, are unnecessarily retarded in their ambulation because their general bodily tone has been allowed to deteriorate due to that lack of exercise which could have been given during the period of enforced recumbency? All patients, whether hospitalized or outpatient, but particularly, those who are ambulatory and under domiciliary care, must be placed on those exercises which will restore function to a maximum degree in the shortest time. These exercises should include those obtained through work therapy.

The patient must be given specific instructions as

Presented at the Symposium on Management of Automobible Injuries at the Annual Meeting of the Ohio State Medical Association, Columbus, Ohio, May 14, 1957.

The Author

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to how, when and why these exercises should be done. This means scrupulous attention to detail on the part of the physician. Unfortunately, many physicians feel they have no time for such detailed supervision. This, however, is just as important an aspect of adequate care as the treatment of the acute emergency and is, therefore, a task which we must not shirk.

One of the best examples of the deficiency of present-day aftercare is that afforded the average civilian amputee. Legion are the surgeons who can perform excellent amputations; pitifully few are those who can supervise the procurement and fitting of an efficiently functioning prosthesis. This problem, usually left to the prosthesis maker whose primary interest is the sale of apparatus, is truly a medical one and should be so handled.

In many instances physical facilities may not be available in the hospital, doctor's office or in the patient's home, or the patient may be the type who will do nothing for himself unless constantly supervised. In such cases the patient should be sent, if possible, to a special center where such facilities and supervision are available. There is a great demand on the part of many lay groups for the establishment of special rehabilitation centers throughout the country.

The need for such facilities, particularly for the seriously injured, cannot be denied. The real need, however, is for the doctor to realize that once he has undertaken the care of a patient, his obligations to that patient cease only when restoration to as near normal as humanly possible has been accomplished. To that end the doctor must learn to administer the most efficient type of aftercare or to utilize the services of those individuals or institutions capable of so doing.

There is an excellent opportunity for much useful work to be done by our educational institutions in offering courses to the medical profession in the use of exercise and work therapy. Much can be done in this respect to improve the end results and to truly rehabilitate our patients whether they suffer from surgical or medical lesions.

Another factor which plays a profound part in the restoration of injured individuals is the recognition of intercurrent medical diseases. Diabetes, nephritis, anemia and vascular lesions, to name a few, may do much to retard convalescence. It is imperative that any surgical case which fails to make satisfactory progress be examined by a competent internist.

Physical Restoration May Be Retarded By Psychological Complications

A factor which all too frequently plays a decisive role in rehabilitation is the development of the psychological complications of trauma. In some intances, psychoneurosis or psychosis may develop to such a degree as to require the aid of a psychiatrist. Lesser degrees of emotional instability with depression due to insecurity precipitated by disability with loss of income may have a profound effect upon the patient's physical recovery. Worry over inability to meet current expenses, to keep a child in school, or to meet mortgage payments is a major factor in the production of such a depression.

This may not seem to be the concern of the doctor but emotional disturbances are, nevertheless, complications of trauma and if the physician will take a few moments for frank discussion he may do much to relieve the patient of his anxiety. Not infrequently, the physician may have knowledge of how financial aid may be obtained and thus afford the patient some relief from his apprehension.

Often, depression may be due to fear of loss of employment either through loss of a job or inability to return to one's regular work. If the physician is aware of this, a telephone call to the employer may result in a promise of work. In cases in which an individual cannot return to his regular work and when jobs are frozen by union seniority rights, discussion with management and union representatives may be productive of a promise of work within the patient's capacity.

It may seem to many that this type of social service is not a duty required of the attending physician. However, as doctors, we are treating sick people and the psychological effects of trauma are as real and as important to the patient and his recovery as any surgical complication. It is our duty to see the patient through his difficulties, mental as well as physical, and to give him any and every assistance possible.

Frequently, a patient is so badly injured that return to regular work is impossible, a fact often obvious to the surgeon within a short time of the injury. If such an appraisal is made, then the patient and his family should be so informed as soon as it is prudent to do so. Efforts should then be made to contact an agency interested in vocational training. The sooner such training is started, the sooner the patient will return to work at his highest attainable skill. It is not fair to the individual to allow him to entertain the hope that he may eventually return to his regular work when he obviously cannot do so.

There are numerous groups and agencies, both public and private, interested in the rehabilitation of the disabled. They ask only prompt referral of

such individuals to them. No one is in a better position than the attending physician knowing his patients needs to see that these facilities are utilized. Most physicians, however, are unaware of the existence of such agencies and it would seem that our medical societies could do much to familiarize their members with the existence, function and utilization of these institutions.

This overall concept of rehabilitation places additional responsibilities upon the medical profession, but the problems created by injury or disease are basically medical problems and must be handled by us as such. We must change our concept that our responsibility to the patient ends with the healing of surgical or medical wounds and this philosophy must be instilled into the minds of medical student, intern, resident and colleague.

It is obvious that factors other than medical care play an important part in the rehabilitation of the injured, the most important being that of litigation. It is but natural that a person, having been injured, should seek recompense for injuries received, particularly when some disability persists. In the final adjudication, our courts and industrial accident boards attempt to make the financial award commensurate with the injury and the degree and permanency of the disability. This is quite proper, if the patient remains disabled after having received the best of medical care and the maximum benefit of all rehabilitation procedures.

Unfortunately, many disabled individuals coming before our tribunals have not had such care. Financial awards under these circumstances leave the individual with a sum of money which he spends and a disability which he keeps. All too frequently, such cases find themselves eventually upon the roles of public welfare.

With the advances made in medical science together with those made in physical and vocational rehabilitation it is questionable whether any injury, no matter how severe, can be considered as being truly totally and permanently disabling, provided the individual is given every opportunity and has the desire and fortitude to rehabilitate himself. In some instances patients will refuse to accept offers of physical and vocational rehabilitation, preferring to keep their disability until the award has been received, believing they can seek aid in rehabilitation themselves after they have received their maximum award. All too frequently they are aided and abetted in this attitude by members of the legal profession whose interest in the size of the financial settlement is not altogether altruistic.

Rehabilitation must be a continuous procedure from the day of accident to that of eventual restoration. The longer the delay in receiving restorative procedures, the poorer the result. Scar becomes more dense, muscles more atrophic and joints more stiffened. In delaying rehabilitation until an award has been obtained, so much time is consumed by the legalistic procedures that disabilities which could have been eliminated by proper treatment do, indeed, become permanent.

Litigation is Incompatible With Rehabilitation

There can be no doubt that the legal concept that every man has his right to his day in court has placed a premium upon disability or that such a concept has flooded our halls of justice with innumerable questionable claims or that the cost of the legal procedures and the eventual financial settlements or awards represent a major item in our economy. Some method must be found to eliminate these claims of dubious injury and disability, for only by so doing can the problems of the truly disabled be seen in their proper perspective. Litigation is one of the greatest barriers to rehabilitation and until it is reduced to a minimum the number of indigent disabled, already of alarming proportions, will continue to increase.

To afford adequate medical care, including physical and vocational rehabilitation to the injured worker there must be a radical change in the attitude and in the laws of our compensation systems based upon the principles of Rehabilitation of the Injured Worker and upon the Operating Principles for a Modern Workman's Compensation System as laid down by the American College of Surgeons.

The problem of rehabilitation of the injured is far more involved than can be discussed in this short time. The employment of the handicapped, including the prejudice of employers in hiring the handicapped or hiring those who have had a serious industrial accident, the penalty inflicted on employers who have hired a handicapped individual who has suffered another injury in their employ and the injustice created by union seniority rights, to union members disabled for their regular work serve to demonstrate the protean complexity of the overall problem.

It is time society took cognizance of the tremendous social and economic repercussions upon the patient, his family and the community created by trauma and disease. We, of medicine, must correct our deficiencies not only for the benefit of our patients but for ourselves for our vulnerability is well known to those socialistically minded individuals, who so critical of medicine, would impose their concept of medical care through legislative action.

Rupture of the Long Head of the Biceps Flexor Cubiti Muscle of the Right Upper Arm

WILLIAM M. HAYES, M.D

RUPTURE of the long head of the biceps flexor cubiti muscle is not a frequent occurrence. No surgeon ever sees many ruptures of the various muscles of the shoulder joint. Cases are overlooked and the patient treated for a sprain. In a rupture of the muscle there is considerable bleeding. In rupture of the tendon there is absolutely no bleeding or it is slight (upper extremity). The tumor mass is movable and is not associated with the skin. When the patient is healthy he feels a slight pain in the upper anterior portion of the arm and a sharp snap or crack when the tendon ruptures as felt in the patient described in the communication. It is noted when the biceps contracts the muscular mass hardens which is located on the top of the upper arm.

This muscular structure frequently ruptures from excessive muscular or passive strain and in the aged often fragments and wears out by attrition. It occurs in young healthy and robust men. Never have I heard of such an accident or its occurrence in a female. I have gone over the records of 235 cases plus the one reported by me.

Inquiries were made at both hospitals located here, Fort Hamilton and Mercy Hospitals, and no records were found of any such a case having been reported at either hospital. The writer served as intern resident, New Orleans, La., Charity Hospital from 1908 till 1910, and while there had the service of Professor Rudolph Matas, who was head of surgery at the Tulane College of Medicine, and never once did I hear him say anything upon this subject, nor did I know of anyone seeing such a case. At that time the hospital had 1235 beds in it.

Petit,[1] in 1722, was the first to report a case of rupture of a muscle, while Chamseru, 1781, was the first to write on the subject. Clemans,[2] stated that the injuries to this muscle are rare. His case was in a railroad worker, 50 years of age, an alcoholic who drank heavily. His muscle tore away from the upper part of the right arm and retracted to the midportion of the upper arm and stayed there. He refused operation. In reporting this case, photographs were made and illustrated the report.

Gilcreest,[3,4,5,6,7] reports on 16 cases, some of which were operated upon and others which were not. In checking over cases operated upon he claims a good result. Bunnell,[8] states he has done a number of cases with success. Steindler,[9] in his textbook states he has operated upon a number of cases of rupture of the middle third of the muscle, the upper extremity and the lower portion, where the muscle is attached to the radius. Thus far he is the only one reporting on the bilateral rupture of the biceps muscle. He reported a case in a man, aged 68 years, in 1942. This patient had a bilateral rupture of the biceps muscle. There was no history of trauma.

DeBakey[10] states he has had one case of rupture of the long head of the biceps muscle. He operated upon the patient successfully and he has fully recovered. Follow-up observation extending over three years shows maintenance of normal function.

Ochsner[11]: Reply was that he has never had a case of his own, but he enclosed a letter from Dr. Harry D. Morris who stated that he has had two cases in the past three years and that Dr. Attix has operated upon one man about eight weeks ago for the same condition. Both Dr. Morris and Dr. Attix are associated with Ochsner Clinic, New Orleans, La.

Anatomy

The anatomy of the biceps muscle is as follows: The biceps or biceps flexos cubiti (m. biceps brachii), is a long fusiform muscle, occupying the whole anterior surface of the arm, and divided above into two portions or heads—the short head from the apex of the coracoid process, the long head from the upper margin of the glenoid cavity. Each tendon is succeeded by an elongated muscle belly. The bellies can be separated from one another up to about three inches of the elbow joint. Here the end is a flattened tendon, which

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● **Dr. Hayes, Hamilton, is a member of the staffs of Fort Hamilton Hospital and Mercy Hospital.**

is inserted in the back part of the tuberosity of the radius.

Function

Actions: The biceps is a flexor of the forearm; it is also a powerful supinator, and serves to render the deep fascia of the forearm by means of the broad aponeurosis given off from its tendon.

Case Report

The patient, male, age 45, when the accident occurred. I originally saw him five years ago, on October 25th, 1952, at the office. His history was as follows: While moving some old material from the front yard at his home, he felt something give way and go down into his right upper arm on the anterior surface. He stopped his work and went into the house to see what was the trouble. He noticed a lump in the right arm on the anterior surface. He then went back into the yard and finished the job he was doing at the time of the accident and decided he would see a doctor the next day.

Physical Examination: The patient was asked to remove his upper clothing, strip down to the waist, and put himself in the direction as shown in the picture (Fig. 1). It was noted that the biceps muscle was on

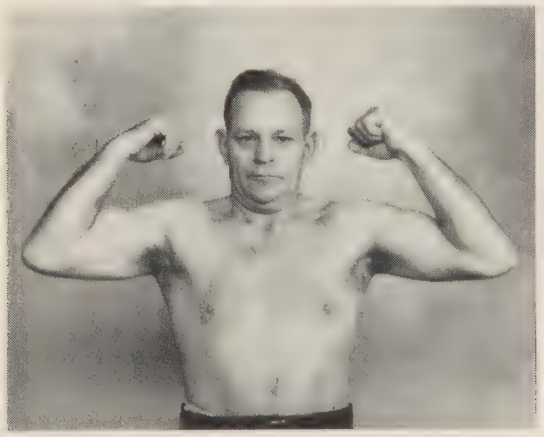


FIG. 1. Note the position of the biceps muscle when the upper extremity is flexed on the right.

the top of the upper arm to a great extent; that is, the greater portion. When he brought his arm down everything was normal. It was finally shown that the long head of the biceps muscle had broken away from its attachment and had slipped down.

It was explained to him that an operation, which was not extensive, would remedy the condition. He said he would go home and discuss it with his wife and let me know about the matter. He returned the next day, October 26th, 1952, and stated that he would let the thing stay as it was. He stated that it gave him no pain, was not disagreeable as far as he was concerned, and he would let the matter stay as it was.

Follow-Up: I saw this patient one year later and found the lesion as it was on the first examination. He said he felt all right and as things were they would remain. When I saw him again on November 16th, 1956, I asked him to let me have a picture of his arm as I wanted to report his case and he agreed.

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Threat to Cardiacs Posed By Bathroom Straining

Heart attack and death may result from bathroom straining by cardiac patients.

On the basis of thousands of patient observations, a research team reports that certain of the changes caused by straining are of sufficient intensity and duration to bring on an automatic cycle of extreme variations in blood pressure and circulation—known as the Valsalva maneuver—in from 12 to 58 per cent of cases.

The authors state: "Our data indicates that physiologic changes following straining may result in serious consequences and if tragic episodes are to be avoided, the immediate correction of constipation with medications such as Senokot® becomes of special importance to the patient with cardiovascular diseases.

"The marked elevations of the arterial blood pressure may constitute a serious problem to those with inelastic atherosed vessels unable to accommodate for these extremes in blood pressure variation," the researchers say. "The decrease in coronary circulation during the Valsalva and its consequent effects poses a specific threat to the patient predisposed to coronary disease."—*Angiology,* April 1958, pp. 99-111.

Atherosclerosis

Even within the scope of the experiments so widely reverenced, a fundamental omission exists. In applying the findings in animals to the problem in man there has been, for the most part, neglect of the observation that arterial occlusion, which may be a grave complication of atherosclerosis, almost never occurs in the animals in which atheromatosis has been induced. This provokes an important question as to whether or not benign atheromatosis of animals is the equivalent, in an etiologic way, to complicated atheromatosis of man. —Edgar V. Allen, M. D., Rochester, Minn.: *Minnesota Med.,* 41:236, April, 1958.

Ruptured Uterine Varix Complicating Pregnancy (Report of Two Cases*)

R. R. MAIER, M. D.

AN entity which has received very little if any attention in the literature is the syndrome associated with the ruptured uterine varix complicating the gravid state. Two such cases have been observed on our service.

Case Reports

The first case, a 26 year old white female, Para I, gravida II, was admitted to the hospital at 6:10 p. m. March 27, 1950. Her prenatal course had been uneventful and her expected date of confinement was May 9, 1950. She gave a history of steady, severe uterine contractions and backache for approximately one hour. There was no nausea or vomiting.

Examination revealed no external vaginal bleeding and an intact bag of waters. Her blood pressure was 118/62. The uterus, the size of a 32 week gestation, appeared tense with no apparent relaxation between contractions. A fetal heart 136 per minute was audible in the left lower quadrant. Her hemoglobin was 65 per cent and she had 3.04 million red blood cell count.

A tentative diagnosis of premature separation of the placenta was made and by 7:50 p. m. under cyclopropane anesthesia, a caesarian section was undertaken. On opening the abdomen free blood was noted. Since the huge gravid uterus made exploration impossible, a low cervical caesarian section was done and a 3 pound female delivered.

Exploration then revealed on the posterior aspect of the uterus, near the junction of the right broad ligament at the level of the lower segment a large varix bleeding freely from a one-quarter inch rent. The latter was closed by two figure of eight sutures. The uterine wound and abdominal wall were then closed in the usual fashion. She was given a transfusion of 500 cc. of whole blood and her convalescence was uneventful.

The second case, a 43 year old white female, Para 0, gravida I, was admitted to the hospital at 5:30 p. m. on July 19, 1955. Her prenatal course had been uneventful and her expected date of confinement was August 26, 1955. She gave a story of severe abdominal pain of five and one-half hours' duration, no external vaginal bleeding and an intact bag of waters.

Examination revealed a blood pressure of 140/65, a hemoglobin of 12.3 grams, a hemtocrit of 37 and white blood cell count of 14,700. The abdomen was tender on palpation and the uterus exhibited a continuous tonicity. It gave the impression of being large, painful and irritable. A faint greenish discoloration suggestive of a Cullen sign was noted in the region of the umbilicus.

A tentative diagnosis of premature separation of the placenta was made and at 9:26 p. m. under spinal Pontocaine® the abdomen was opened. A considerable quantity of free blood and clots was immediately encountered, but no bleeding point could be located. The uterus was therefore emptied by a low cervical caesarian section delivering a 4 pound 4 ounce female. The placenta was quickly removed, the uterine wound closed and the pelvis explored.

A large varix on the posterior aspect of the lower uterine segment just above the right uterosacral ligament was found to be steadily oozing. The varix was ligated by means of two figure of eight sutures. The blood and clots were removed and closure of the abdomen effected in the usual fashion. The patient was given iron, antibiotics prophylactically and had a completely uneventful convalescence.

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The Author

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Discussion

Two instances of ruptured uterine varices at approximately the 32nd to 35th week of gestation have been reported. Neither case gave a history of external trauma. Both pictures were very similar with severe pain and tonic uteri so that in each case a preoperative diagnosis of premature separation of the placenta was entertained. Neither case showed evidence of shock and yet both showed considerable free blood in the abdominal cavity.

One can only postulate that the large gravid uterus may have exerted a tamponading effect so that the blood loss was only intermittent. In hindsight it is fortunate that the signs although simulating another entity were sufficiently acute to precipitate exploration and thus avoid considerably more blood loss and perhaps a less fortunate outcome.

The only clue to the true picture was the possible Cullen sign which was noted only in passing.

Acknowledgment is given to Dr. M. B. Laven for permission to present his case.

Diabetic Acidosis

Patients with acidosis of moderate severity will survive if treated by any of several methods, but those with increasingly severe acidosis seem to approach a point of irreversibility beyond which no amount of knowledge will bring successful results. As the severity of the acidosis approaches this point, the margin of error permitted the physician becomes less and less; and in severe acidosis the treatment must be adapted to the needs of the moment with a maximum of precision.—Clifford F. Gastineau, M. D., Rochester, Minn.: *J. M. A. Georgia,* 47:183, April, 1958.

Suppression Amblyopia:

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

At the age of 2 years, the left eye of this 7 year old girl was first noted to converge. The parents apparently did not realize the seriousness of the condition, and neglected their child for five years. Examination showed 20/20 vision right eye and ability only to count fingers left eye. The left eye was 20 degrees convergent, and central suppression was so marked that the child could not hold this eye straight even when the right eye was covered. In all other respects the left eye was perfectly normal, showing no defect of the retina, optic nerve, or other structures.

The diagnosis of suppression amblyopia was made. Because of the severity of visual loss and the age of the child it was evident that it was too late to restore vision in this eye. Recession-resection surgery was performed on the left eye with a cosmetically straight result.

Discussion

If the two eyes are not straight, conflicting images are sent to the brain and diplopia results. We have the ability, within limits, to suppress one of these conflicting images, and do so unconsciously whenever we look through a monocular microscope or an ophthalmoscope. This same suppression occurs in children with strabismus, but will often become severe and irreversible, especially if the same eye always deviates. Fully developed suppression amblyopia will reduce vision to 20/200 or less. Proper ophthalmological care can prevent this visual loss, or can usually restore vision if the child is seen early enough. Almost invariably by the age of 6 it is too late to restore vision to these children, who are doomed to go through life with only one good eye.

The frequency of suppression amblyopia is not realized by most physicians. One to 2 per cent of adults have vision of 20/200 or less in one eye due to suppression amblyopia! The great majority of these amblyopic eyes could have been prevented by early detection and treatment.

Two thirds of amblyopia is due to strabismus which may readily be detected by observation. One of the quickest ways of detecting gross deviations is to sight over a flashlight directed towards the patient's face. If the child is looking at the light, the brilliant corneal reflections will normally be perfectly symmetrical in the pupil on the two sides. Eccentric displacement of the reflection in one pupil indicates strabismus.

One third of suppression amblyopia is due to monocular error of refraction. The easiest way to detect this is by preschool vision screening with E charts. Vision can be adequately checked in most children by the age of 4 or 5 years. Testing of visual acuity should be incorporated in routine physical examination of preschool children, because it will detect suppression amblyopia in time to permit therapy (one of every 100 children through *your* office). Vision testing will also detect refractive errors, or any type of eye pathology causing reduction in vision.

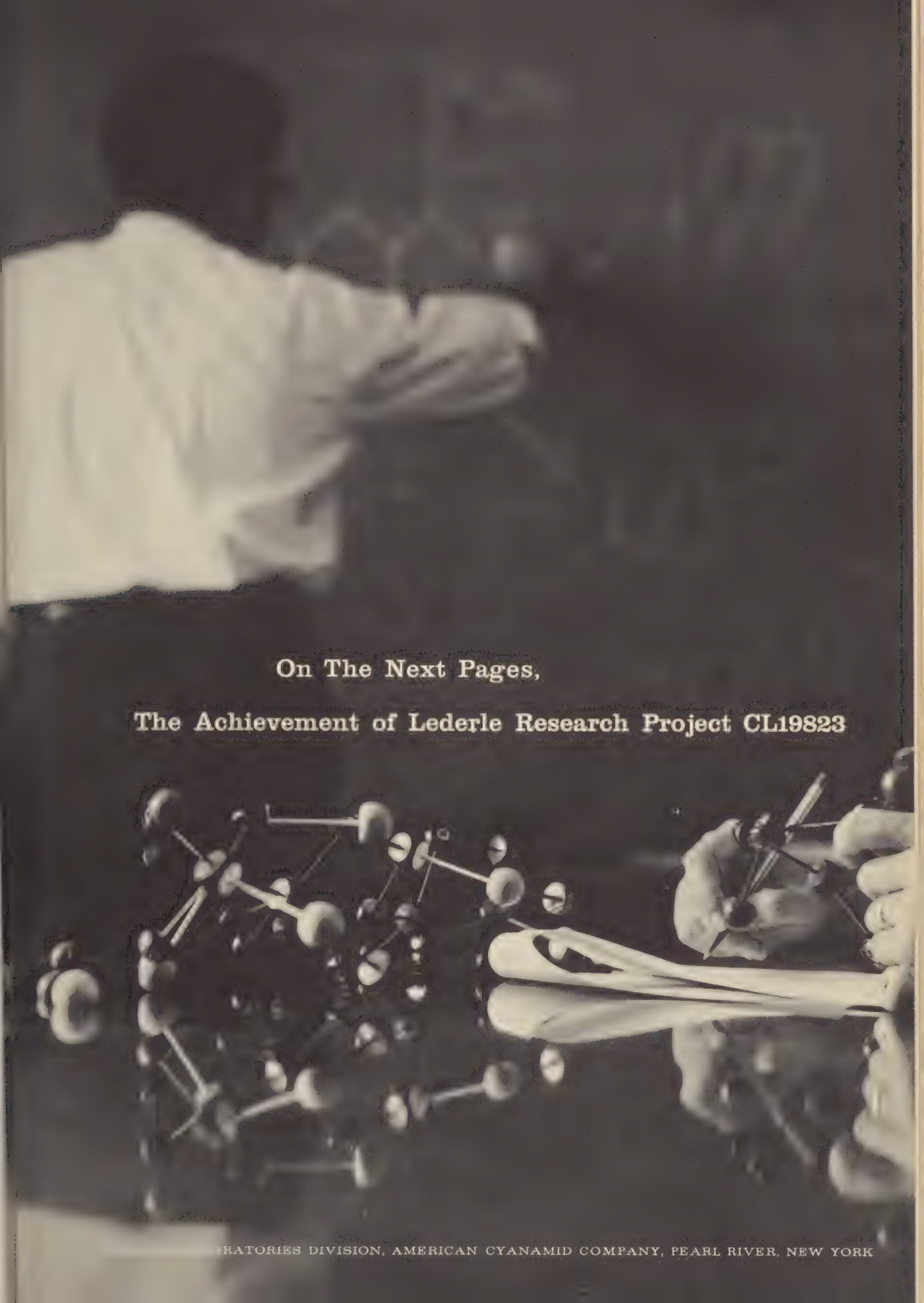
Any child with strabismus should be referred *promptly* to a physician skilled in eye care. (Optometrists are not prepared to manage these children.) Refraction, strabismus measurements, and orthoptic care, as well as careful ophthalmoscopic and other routine ophthalmologic studies are indicated. Not infrequently strabismus may be the first sign of serious intracranial or ocular disease. One of the most pernicious of old wive's tales runs thus, "Don't take the crosseyed child to the doctor —he will outgrow it and besides he's too young to be examined anyway." Such a belief destroyed irreversibly vision in the left eye of the little girl reported in this article.

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● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

Bacterial Population

If the established bacterial population has been weakened, or if its internal equilibrium has recently been disturbed, the invader may be aided tremendously in its aggression.—H. K. Kersten, M. D., Fort Dodge: *J. Iowa M. Soc.*, 48:240, May, 1958.

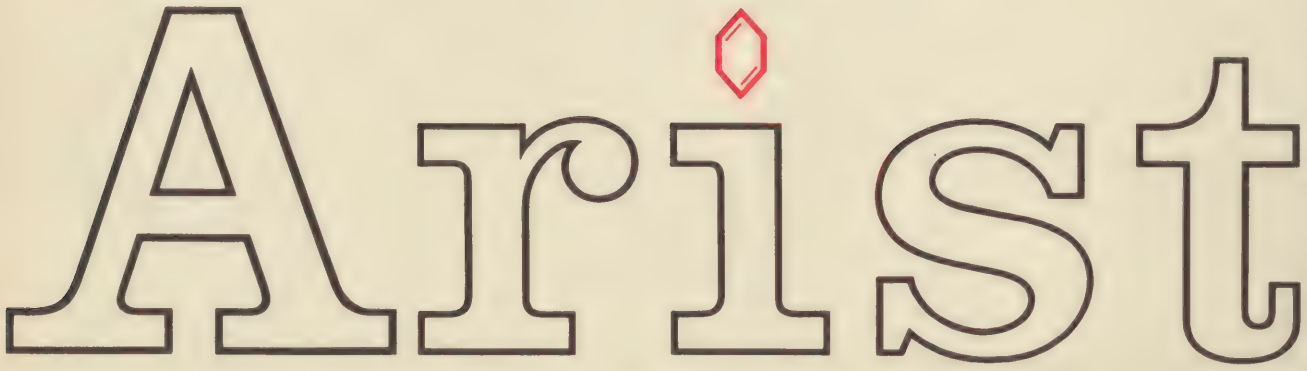


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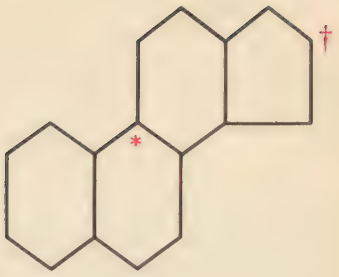
The Achievement of Lederle Research Project CL19823

RATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Lederle announces a major drug with great new promise



a new corticosteroid created to minimize
major deterrents to all previous steroid therapy



ocort®

Triamcinolone LEDERLE
9 alpha-fluoro-16 alpha-hydroxyprednisolone

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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
  - No sodium or water retention
  - No potassium loss
  - No interference with psychic equilibrium
  - Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension—Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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1. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957. 2. Hartung, E. F.: Paper presented at Florida Academy of General Practice, St. Petersburg, Florida, Nov. 2, 1957.

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The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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1. Sherwood, H., and Cooke, R. A.: J. Allergy 28:97, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Schwartz, E.: Personal Communication. 4. Spies, T. D.: Personal Communication. 5. Barach, A. L.: Personal Communication. 6. Segal, M. S.: Personal Communication.

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The Promise of Aristocort

in Nephrotic Syndrome

Fourteen patients with the nephrotic syndrome have been treated with ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

Eleven patients with pulmonary emphysema and/or fibrosis were treated with ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

Forty-four children and adults have been given ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◊ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

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in Disseminated Lupus Erythematosus

◊ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

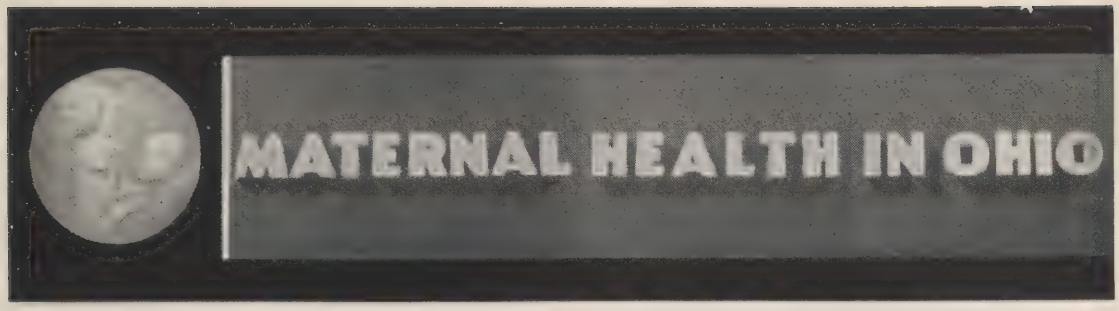
In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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Case No. 30

This patient was a 40 year old, white gravida III, Para II, who died undelivered. Her past history was not remarkable; there were two previous term pregnancies delivered without complication. The last menstrual period was April 1, and was a few days late; heavy flow 3 to 4 days. At 9 a. m. on April 10 she was seen by her physician at home, complaining of nausea, pain in her lower left abdomen and diarrhea with rectal tenesmus. She had eaten before retiring the night before and was unable to sleep because of "indigestion." (There was a prevalence of "virus diarrhea" at the time.)

On examination patient was acutely ill with "general abdominal soreness." Temperature was normal, blood pressure 100/60. (No other examination reported.) The physician's impression was "acute gastroenteritis" and the patient was given a sedative and was advised to call back in four hours. In four hours the patient was dead, at home. An autopsy was performed.

Pathological Diagnosis: Ruptured ectopic pregnancy, right; massive internal hemorrhage.

Comment

Several points of question came from the Committee as it studied this case: What was the pulse rate, the result of abdominal examination, and vaginal or rectal examination, and was the previous (March) period normal? Although the patient was reported to appear "acutely ill," cold, moist clammy skin and apprehensive sensorium are not reported! The fact that a prevalence of common diarrhea and "virus" diseases can easily mislead the physician into a diagnostic error, is clearly demonstrated.

The Committee voted this case a preventable maternal death.

Case No. 103

This patient was a 41 year old, white gravida IV, Para III, who died undelivered. Nothing is known of her past history or the past pregnancies—it is believed she had two deliveries at term. The dates of her last several menstrual periods are not known. She lived in a rural area and it is not known that a physician was called to see her. She died at home on November 2. The coroner performed the autopsy.

Pathological Diagnosis: Exsanguination, abdominal hemorrhage; ruptured ectopic pregnancy (interstitial, approximately 14 weeks). The pathologist's report further explained the male fetus was delivered from the abdominal cavity, was attached to the umbilical cord, and it measured 8 cm. (crown-breech) or 11 cm. (total length). The fetus was in a sac, placenta was free. The uterus measured 12 by 7 by 5 cm. and laceration at the right upper pole, inside of which was a cavity measuring 5 by 6 cm., the wall of which contained placental fragments and clots.

TOPIC THIS MONTH:

Maternal Deaths* Involving Ectopic Pregnancy

Comment

This rather uncommon variety of ectopic pregnancy (3 to 4 per cent of the cases) provides a tremendous challenge in prompt, accurate diagnosis (before rupture) for even the expert! The Committee felt hampered again in assessing responsibility, since the available information indicates that no physician was given an opportunity to make a diagnosis before death. From available data, this case was voted a preventable maternal death, (P_1 patient responsibility).

Case No. 222

The patient was a 27 year old, colored, Para II, gravida (?), who died undelivered. She was first seen in the emergency room of first hospital November 30 at 10:55 a. m. with last menstrual period normal, two to three weeks before examination. At 9:00 a. m. on that day, following breakfast she developed abdominal pain and vomited three times. There had been no bowel movement for two days. One year previously she had experienced a similar attack. No other past medical or obstetrical history was obtained. Temperature was not recorded; blood pressure 130/70; pulse 100 per minute. Examination was said to have revealed no positive abdominal signs, although the examiner found the patient "difficult to examine." No pelvic or rectal examination or blood work was recorded.

A tentative diagnosis of "gastroenteritis" was made and the patient was given atropine gr. 1/150 and phenobarbital gr. 1 and directed to go home to bed and return if her symptoms persisted. At 4:00 p. m. that day a baby sitter did not like the manner of the patient's breathing, notified a hospital and the patient was sent by police

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

ambulance to the emergency room, where she was pronounced dead on arrival, 4:45 p. m. November 30. An autopsy was performed.

Pathological Diagnosis: (Coroner's report)—Ruptured ectopic pregnancy (tubal); old pelvic inflammatory disease; chronic cervicitis; fibrous metasplasia of breasts.

Comment

The Committee was hampered in complete evaluation of the case by a lack of information on the history, physical findings and no effort to report any simple laboratory studies and their results. The general appearance of the patient, viz. "obese," "thin," "comfortable," "in shock," etc., are considered important elementary observations, and are of great assistance in the review of a case; these were not reported. Although the patient's temperature was not reported, a rapid pulse (100 per minute) should provoke suspicion of some vascular or cardiac pathology, provided it remains rapid in several examinations over a quarter of an hour or so. The Committee voted this case a preventable maternal death.

Comment of Consultant

The following comment of a consultant who is a specialist in Obstetrics and Gynecology was given at the request of the Committee.

Death from obstetrical hemorrhage is still one of the major causes of maternal mortality in the United States; hemorrhage from ectopic pregnancy causes approximately one fourth to one fifth of all maternal deaths due to hemorrhage.

It does appear that the main factors causing delay in treatment of extrauterine pregnancy are principally (1) overlooking the primary diagnosis, and (2) hesitancy in instituting treatment in doubtful cases.

In **Cases No. 33** and **No. 222** the diagnosis of extrauterine pregnancy apparently was not suspected by attending physicians. The information on **Case No. 103** is too scanty for comment, except that it is possible that a physician could have prevented the tragedy if he had been consulted.

A carefully taken history in cases of suspected ectopic pregnancy is by far the most important diagnostic aid in our armamentarium. It is important to consider any woman of childbearing age as having a possible ectopic pregnancy whenever she complains of irregular vaginal bleeding and abdominal pain. No single sign, with the exception of pain, is present in any great number of cases. Acute tenderness on manipulation of the cervix is a common finding in ruptured ectopic pregnancy. A rapid decrease on repeated counts of hemoglobin is a valuable finding, as is an anemia more severe than can be reasonably accounted for by the history of external blood loss. Leukocyte counts show a great variation in ruptured ectopic pregnancy and temperature elevation of 100°-101° are seen in approximately one third of ectopic pregnancies. It is important to realize that the biologic test for pregnancy on urine is *negative* in about one third of extrauterine pregnancies.

We are convinced that the routine use of colpopuncture or posterior colpotomy for old clotted blood in the abdominal cavity will materially reduce the serious delays in diagnosis and treatment of this very serious condition. The aspiration of clotted blood makes a laparotomy mandatory in order to locate and remove the *source* of the in traabdominal bleeding.

There can be little doubt that if an ectopic pregnancy could be diagnosed when the symptoms appear and be promptly operated upon, the mortality would be slightly greater than that for other uncomplicated surgery of the abdominal cavity.

Relative Value of Different Thyroid Tests

I would use the various tests, there is a place for each one of them. I would make use of basal metabolic reading, and I would think one could make use of basal metabolic readings better in the office than in the hospital. . . . In the quiet of one's own office with one's own technician, the patient may come in early in the morning and relax for a half hour. I think one gets a better reading there. I am convinced that I do in my own office. The BMR is not a difficult test and I think with the newer technics and newer machinery, I should say, it is not uncomfortable for the patient to take a BMR.

The cholesterols—yes. All are sensitive of cholesterol today, so it is a good idea to take that routinely and for different reasons. The iodine uptake test is becoming more usable in that one now can secure the I^{131} easier than formerly and does not have to go to special hospitals in order to have it done. I hope it will be more extensively used because certainly there are instances in which it can be of definite diagnostic differential benefit. The serum iodine determination is expensive today because of the difficulty of the technic, the time it takes a technician to run it, and certainly in private offices it would be a most difficult procedure to attempt. At certain centers, such as the medical schools, one could have them run, but, as I have said, it is an expensive procedure and I really believe that unless one is completely befuddled concerning his diagnosis, for the time being one could get along without it.—Edward H. Hashinger, M. D., Kansas City: *Missouri Med.*, 55:471, May, 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 77 year old white female had been apparently in good health until five months prior to admission to the University Hospital, Columbus, when she developed weakness, dyspnea, ankle edema and orthopnea. She was hospitalized and treated with digitalis, mercurial diuretics and a low-salt diet. The response to this therapy was good and she was discharged after 10 days. After an unspecified time she developed a widespread pruritic rash and all medication except digitalis was discontinued. Slowly her dyspnea and ankle edema returned.

She developed ulcers of her legs and was again hospitalized. Her digitalis was continued in amounts of 0.1 Gm. per day, and she also received vitamins and later streptomycin and Terramycin® for a B. coli urinary infection. While she was in the hospital her nonprotein nitrogen slowly rose, her pyuria persisted, she became confused and disoriented and developed small bilateral pleural effusions. Two weeks prior to her admission to University Hospital she received 1 unit of blood for hypochromic anemia.

Previous Illnesses: She had jaundice many years ago which disappeared without sequelae. She fractured her left hip in 1956. There was no history of rheumatic fever, scarlet fever, gallbladder, renal or skin disease previous to her present illness.

Physical Examination

The patient was a somewhat pale, thin, slightly disoriented white female who was unable to give a reliable history and appeared moderately agitated. She showed healing excoriations of her skin over many areas. Her temperature was 98° F.; her pulse was of rather poor volume and showed an irregular irregularity; her respirations were 25 and her blood pressure was 140 over 90. The neck veins were not distended. She showed 1 to 2 plus pitting edema from both ankles to her thighs and had stasis ulcers over the inner aspects of both lower legs. Her chest showed an increased postero-anterior diameter and moist crackling rales were audible over the base of the left lung.

Examination of the heart revealed the heart beat in the left anterior axillary line in the fifth interspace. A harsh grade 4 systolic murmur was heard, loudest over the apex, along the left sternal edge and the aortic area, radiating into the neck and left axilla; it was accompanied by a systolic thrill, and the second heart sound was absent over the aortic area; no diastolic murmurs were audible. Examination of the abdomen, and all neurological tests were unremarkable.

Presented by

- Joseph M. Ryan, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.

Laboratory Findings

Her admission blood count was: red blood cells 5.75 million with 7.2 per cent reticulocytes; hemoglobin 12 Gm.; white blood cells 11,000 with 70 per cent polymorphonuclears, 20 per cent lymphocytes, 10 per cent monocytes; platelets 598,000. Her sedimentation rate was 0.1 ml. per minute; the hematocrit was 42 per cent. Examination of her urine showed a specific gravity of 1.015, a *p*H of 5, 30 mg. of protein and many white blood cells and 8 to 12 red blood cells per high power field; E. coli, Klebsiella and enterococci were grown on culture. Her blood urea nitrogen was 73 mg., her blood sugar 124 mg., the CO_2 combining power 62 vol.; the serum sodium was 146 mEq., the serum potassium 5.8 mEq., and the serum chlorides 107 mEq. The van den Bergh was 2.7 mg. direct and 4.3 mg. indirect; the thymol turbidity test was 50 mg. Serology was normal. No pathogens were isolated from her feces.

Roentgenographic Findings

X-ray examination of her chest on the second day of her hospital stay showed an enlarged heart, an increased vascularity of her lungs with suggestion of small costophrenic angle effusions, and the aortic shadow appeared widened.

Hospital Course

The patient's temperature remained normal throughout her stay in the hospital. She was incontinent the entire time and appeared confused

at times though fairly lucid at other times. She received streptomycin for the first three hospital days; tetracycline on the second and third days; Diamox®, 250 mg. daily, for the terminal four days, and digitalis on the second and last hospital days. An intravenous injection of Mercuhydrin® was given on the fifth day. Her condition showed no essential change while she was in the hospital, though her blood urea nitrogen dropped to 54 mg. by the fifth hospital day. She died quietly during sleep at 1 a.m. on the eighth hospital day.

Clinical Discussion

DR. RYAN: This 77 year old woman began to have symptoms five months before she was admitted and died on the eighth hospital day. This represents an important clinical aspect of this case because it means that she suffered from a progressive illness that never let loose of her. To me it seems a pretty clear-cut case of heart failure. She developed weakness, which is a classical symptom of heart failure, dyspnea, ankle edema and orthopnea which responded well to treatment for congestive failure. Slowly her symptoms returned and she developed varicose leg ulcers and some renal infection.

Her nonprotein nitrogen rose slowly and she became confused. It seems to me here again that we are dealing with an individual who is sliding into heart failure once more. Certainly I attribute her bilateral pleural effusions to this. Cardiac failure also can explain her rising blood urea nitrogen, and when you add cardiac failure to 77 year old cerebral vessels I believe one could become disoriented and confused on this basis. Pallor is frequently observed in persons with an inadequate circulation because the peripheral circulation shuts down in an effort to keep the blood moving to the parts that need it most, such as the brain or the heart.

Her blood pressure does not quite agree with her poor volume pulse, and one wonders how reliable in a patient with irregular irregularity the blood pressure is, because the systolic as well as the diastolic pressure varies greatly in atrial fibrillation. The ulcers could well be stasis ulcers, which are not at all uncommon in patients with congestive failure. She evidently had a big heart, which would go along well with congestive heart failure. The various murmurs I think have an important bearing on what we will find on postmortem examination of this heart.

I was surprised that her liver was not a little enlarged, I certainly would expect it. The next important things were the urinary findings which suggest an acute urinary tract infection. Still there are other things, like vulvitis, that can contaminate the urine of a female of her age. We see no evidence of diabetes, and her serum electrolytes were normal except for a slight elevation of potassium. I am somewhat puzzled by her liver function tests, which suggest some type of liver damage. A chest film confirmed her large heart. I wonder if Dr. Elson would care to say a few words?

DR. ELSON: Her heart was big and dilated, and you could see vascular congestion of both lungs. These findings are compatible with a heart in congestive failure, and that is about all we can say.

DR. RYAN: Dr. Elson is to be complimented in not trying to pinpoint definitive chamber enlargement too closely in the face of frank congestive failure, because all chambers produce big shadows when you have congestive heart failure. The heart is much fuller of blood than it was before it failed.

Heart Disease

We know therefore that this patient had heart disease because she had the most reliable sign of heart disease that we can have: a big heart with evidence of congestive failure. Now the question comes up of what kind of heart disease she had. First let's consider what kind of heart disease you could encounter in a 77 year old female. First, one will think of arteriosclerotic heart disease because of her age, but age alone is not a sound enough basis for such a diagnosis. Certainly many people dying of other causes at 77 have some coronary disease but not severe enough to cause any cardiac dysfunction. We don't know what the electrocardiogram showed, but we have no history of anything suggesting angina pectoris or myocardial infarction, and we don't think she had diabetes.

Next, somebody might wonder about hypertensive heart disease. Her blood pressure was not elevated, although we know that this may drop in the face of cardiac failure in a hypertensive individual to rather normotensive levels. But an individual who has hypertension significant enough to cause him to die of hypertensive heart disease does not live to reach 77. It is not an infallible rule, but patients usually die before they reach this age. My suggestion is that this woman had rheumatic heart disease with aortic stenosis. The lesion is more common in men, I will admit, but this does not mean that she cannot have rheumatic heart disease with arotic stenosis, in which I include the calcific aortic stenosis of the aged. I believe that aortic stenosis is invariably due to previous rheumatic infection and I don't believe that arteriosclerosis can produce this lesion.

What is our evidence for aortic stenosis in this patient? Her big heart and this loud systolic



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murmur over the apex accompanied by a systolic thrill over the aortic area. In addition the second aortic sound was absent, her pulse was of small volume, and her congestive failure developed pretty rapidly. Once these patients with aortic stenosis start to fail, they fail pretty fast. This is in contrast to the individuals with mitral stenosis, who may have numerous bouts of heart failure and keep restoring to a reasonable state of compensation before they ultimately die.

The only other kind of heart disease that one would be justified in considering, only to dismiss it in view of the physical findings, would be what I would like to call senescent heart disease. This occurs in old persons who go into heart failure without angina, infarction or hypertension. I admit this is just anther way of saying that I don't know what kind of heart disease the old person has, but I don't believe it is identical with arteriosclerotic heart disease. On the other hand, this could not explain all the murmurs that we have here and therefore I mention it only to dismiss it.

Blood in Urine

Now what else did this patient have? We are almost forced to make the diagnosis of pyelonephritis with all the pus and blood in the urine, but we can only speculate as to its etiological background. How can we explain her subclinical jaundice? One may think that she developed a subacute bacterial endocarditis with a hemolytic type of organism, which is a little hard to believe in the face of a 5.7 million red cell count. We do know that people with longstanding congestive failure with engorged livers have mild liver dysfunction with mild icterus and mild elevations of serum bilirubin, and I think that that's the way we have to explain it because we have nothing else to go on.

If we are searching for a "sleeper," we should think of bacterial endocarditis. What facts speak against such a diagnosis? Well, we have no embolic phenomenon, no anemia, and it is very unusual to find atrial fibrillation in the face of acute bacterial endocarditis. Also it is very uncommon to find subacute bacterial endocarditis in an individual who already is in heart failure.

So in summarizing I would say that this woman had rheumatic heart disease with calcific aortic stenosis. We don't have any evidence of any other valves involved, although as you know, isolated aortic involvement is not too common. I think she had frank congestive heart failure with liver engorgement and mild jaundice, and I think she had acute and chronic pyelonephritis and died from a combination of lots of things: Heart failure, hypostatic pneumonia and renal insufficiency on a pyelonephritic basis aggravated by cardiac failure. I must say I am at a loss to explain 5.7 million red cells and 7 per cent reticulocyte response. I think her jaundice may well have been on the basis of liver engorgement. As a possible "sleeper" I might mention subacute bacterial endocarditis but without the typical picture.

General Clinical Discussion

QUESTION: Dr. Ryan is the thymol turbidity test elevated that much in liver insufficiency caused by passive congestion?

DR. RYAN: I think so, at times.

QUESTION: Can anoxia produce the reticulocyte response?

DR. RYAN: Well I don't think so. If you measure atrial oxygen saturation in individuals with congestive failure, it is low normal or just slightly reduced.

QUESTION: Do rheumatics usually wait this long to get into difficulty with their chronic valvular heart disease?

DR. RYAN: There are some who still believe that aortic stenosis at this age may be due to arteriosclerosis. I don't think the evidence is very convincing and I don't think there is any reason that these people can't have had rheumatic fever in the past.

Clinical Diagnosis

1. Rheumatic heart disease with calcific aortic stenosis and congestive failure.
2. Chronic passive congestion of the liver with jaundice.
3. Chronic pyelonephritis.

Pathological Diagnosis

1. Myocardial infarctions, old and recent.
2. Rheumatic heart disease, inactive.
   (a) Calcific aortic stenosis.
   (b) Calcified mitral valve.
3. Pulmonary embolus, multiple.
   (a) Hemorrhagic infarction of the lung.
4. Chronic pyelonephritis.

Pathological Discussion

DR. VON HAAM: Dr. Ryan must be congratulated for his firm stand and for the sound arguments in his clinical discussion. The body was not jaundiced, was slightly cyanotic, and both extremities were edematous and showed extensive superficial ulcerations over both tibias. The patient had a hydrothorax with about 600 cc. of fluid in each side.

The heart was enlarged and weighed 550 grams. The right auricular appendage appeared almost completely obliterated by a fresh thrombus. The

leaflets of the mitral valve were thickened and shortened and the ostium appeared partly stenosed by calcium deposits around the margin. The aortic valve was stenosed to such degree that not even a fingertip could be passed through the ostium. The cusps appeared fixed and completely calcified. The myocardium showed a circumscribed whitish scar in the septum and smaller areas of yellow mottling. The coronaries were sclerosed but no occlusion of the lumen could be demonstrated.

The lungs were slightly edematous and the right lower lobe contained a small recent infarct. The liver showed the typical gross appearance of chronic passive congestion of some standing. The kidneys were slightly granular and contained deep, pitted scars characteristic of chronic pyelonephritis.

Microscopic Examination

Sections of the heart valves showed changes compatible with healed rheumatic heart disease with calcium deposits in the aortic cusps and mitral leaflets. Sections through the myocardium showed also the perivascular scars observed in healed rheumatic myocarditis. In addition to these changes, rather severe scar tissue could be observed typical of a healed infarct, and recent areas of necrosis as observed in fresh or progressive myocardial infarction. Some of these lesions extended to the endocardium and were covered by the previously described mural thrombus.

Sections through the lung showed extensive and large accumulations of heart failure cells and marked thickening of the medium-sized pulmonary vessels. The liver in addition to chronic passive congestion showed fatty changes and evidence of malnutrition with vitamin deficiency. Sections of the kidneys showed a chronic, mildly active pyelonephritis.

In summary then we can state that the patient indeed suffered from the sequelae of severe rheumatic heart disease with calcific aortic stenosis and less severe mitral valve involvement. In addition to this condition she suffered from arteriosclerotic heart disease which produced mural thrombi and myocardial necrosis. This condition was overshadowed clinically by the physical signs of her valvular lesion, but it was quite progressive and probably represented the true cause for her rather rapid congestive failure. The patient's polycythemia, which Dr. Ryan was puzzled about, can probably be explained on the basis of pulmonary hypertension which was at least partially caused by her mitral valve lesion.

General Discussion

DR. RYAN: Lesions simulating coronary artery disease are not at all uncommon in aortic stenosis with severe left ventricular hypertrophy. If one has minimal coronary disease and then adds on top of it a big, thick left ventricle and aortic stenosis, we may get those myocardial infarcts without coronary occlusion such as in this patient. Here then the aortic stenosis might still be the main culprit in the whole problem.

DR. VON HAAM: Can a severe aortic stenosis with moderate mitral valve insufficiency produce pulmonary hypertension?

DR. RYAN: No. I think patients usually develop heart failure before pulmonary hypertension can be established. In this case the patient must probably have had a more severe functional stenosis of her mitral ostium than we presumed from the autopsy. A significant factor in heart failure is not the rising diastolic pressure but the decrease in cardiac output which always precedes the appearance of elevated venous pressure.

Periarteritis and Hypertension

Although periarteritis nodosa is a relatively uncommon disease, it has aroused considerable interest and controversy since its original description by Kussmaul and Maier in 1852. Since that time more than 750 cases have been reported in the medical literature, and they have continually attracted widespread interest in the clinical, morphological, and therapeutic problems of this disorder. The increasing incidence of periarteritis as a sequel to the administration of sulfanilamides, serum, penicillin, and other chemotherapeutics has further indicated the need for increasing medical knowledge concerning the pathogenesis of this vascular disease.

Hypertension, hypersensitivity, kidney damage, and various hormonal factors, such as DOCA and anterior pituitary extract, have been cited to play a role in the etiology of periarteritis. Rich, Germuth, and Hawn and Jawneway have emphasized hypersensitivity as a factor in pathogenesis; Selye et al. and Perry have stressed hormonal influences in the development of periarteritis; Smith and Zeek, Wilson and Pickering, and Goldblatt have considered hypertension as most important in its etiology.

Wilson and Pickering and Goldblatt have stated that a critical level of blood pressure must be reached for periarteritis to develop. Smith and Zeek feel that if the blood pressure is below 200 mm. Hg., periarteritis will not develop. They also state, "There are no reports of periarteritis nodosa in animals whose blood pressures were proven normal or whose kidneys were proven free of pathologic change."—Ben D. McCallister, M. D., Honolulu: *J. Kansas M. Soc.*, 59:141, April, 1958.


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The New President-Elect and Two New Councilors Elected in Cincinnati By the House of Delegates, with Data on Other Members of The Council

THE HOUSE OF DELEGATES of the Ohio State Medical Association named a President-Elect and two new Councilors at the 1958 Annual Meeting in Cincinnati. Following are biographical sketches of these new officers and information on other members of The Council.

Dr. Frank Henderson Mayfield was named by the House of Delegates as President-Elect of the Association to take the office of President at the close of the 1959 Annual Meeting in Columbus. Dr. Mayfield is a practicing physician in Cincinnati in the field of neurological surgery. He has distinguished himself in his practice as well as in the fields of medical education, military medicine and medical organization work.

Dr. Mayfield's election to the high office came after he had served nearly two years on The Council as Councilor from the First District. He had further served the OSMA as chairman of its Committee on Public Relations and Economics and as chairman of the Subcommittee on Legislation. A former President of the Academy of Medicine of Cincinnati, he has held numerous offices and committee appointments in that Society.



Frank H. Mayfield, M. D.

Dr. Mayfield is a diplomate of the American Board of Neurological Surgery, assistant professor of clinical surgery in the University of Cincinnati College of Medicine, and a member of the Board of Trustees of the University. Professional appointments include those on the attending or consulting staffs of many Cincinnati hospitals as well as those of neighboring cities.

Nationally, Dr. Mayfield has held several positions of high responsibility. A Fellow of the American College of Surgeons, he is on its Board of Governors and is chairman of its Subcommittee on Head Trauma. He is also a Fellow and Past-President of the American Society of Neurological Surgeons; has served as vice-chairman of the Section on Nervous and Mental Diseases of the American Medical Association.

During World War II, Dr. Mayfield served from August, 1942 to February, 1946 in the Army Medical Corps. With the rank of Lieutenant-Colonel, he served as chief of the Neurological Surgery Section, Percy Jones General Hospital Battle Creek, Mich., a U. S. Army hospital. At present he is area consultant in neurosurgery for the Veterans Administration.

Dr. Mayfield is a native of Garnet, South Carolina, and earned his degree as Doctor of Medicine in the Medical College of Virginia, Class of 1931. He took his internship at the Hospital Division of the same college and went immediately into residency training in neuro-

surgery. In 1935 he accepted an appointment as instructor in neurosurgery at the University of Louisville School of Medicine and the following two years was assistant to Dr. R. Glen Spurling, Louisville neurologist and medical educator.

Incoming President

Dr. George A. Woodhouse, Pleasant Hill, assumed the office of President at the conclusion of the final meeting of the House of Delegates.

Dr. Woodhouse began his career as a rural practitioner and has devoted himself to that field since. The major part of his professional life has been in and around the Miami County community, where he early took an interest in medical organization work. Five years ago his colleagues of the Miami County Medical Society honored him with a testimonial dinner upon completion of 25 years as secretary-treasurer of the local organization. Recently he was again honored by the local Society with a plaque and a resolution commending his many years of service in behalf of the medical profession.



Geo. A. Woodhouse, M.D.

On the state level, Dr. Woodhouse served four years as Councilor of the Second District before he was named President-Elect in 1957. On the national level he has continuously served as Delegate to the American Medical Association since 1942 and for five years has been a member of the Judicial Council of the AMA. The Judicial Council has been called medicine's supreme court. Its function is to interpret the AMA Principles of Ethics.

As early as 1936 Dr. Woodhouse was elected president of the Second Councilor District Medical Society and later served several terms as its secretary. He was first elected a delegate of the Miami County Medical Society to the OSMA in 1936 and served in that capacity until 1953. He has served the State Association in many capacities—as a member of the first Judicial and Professional Relations Committee; a member of the committee to study plans for pre-payment insurance, a program which resulted in establishment of Ohio Medical Indemnity; member of the Committee on Public Relations and Economics; member of the Subcommittee on Legislation and its chairman from 1949 to 1953; member of the House of Delegates Reference Committee on Resolutions on many occasions; chairman of the Committee on Hospital Relations for one year; and a member of the Auditing and Appropriations Committee.

Dr. Woodhouse is a graduate of the University of Cincinnati College of Medicine, Class of 1924. He is a member of the active staff of Piqua Memorial and Dettmer Hospitals and on the courtesy staff of Stouder Memorial Hospital, all in Miami County. He is married and the father of four children, all adults. One son, Dr. George A. Woodhouse, Jr., is a practicing physician in Cincinnati.

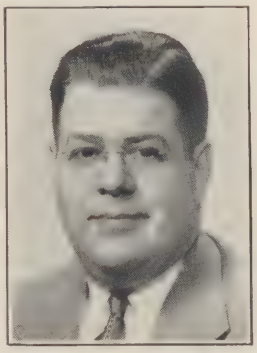
Dr. Woodhouse is a member of the Hospital Advisory Council of the Ohio Department of Health. Community activities include membership on the local Board of Education and the Pleasant Hill Board of Public Affairs of which he has been president for eight years. He is a member of the Congregational Christian Church, the American Legion (as a veteran of World War I) and several Masonic bodies including the Shrine.

First District Councilor

The House of Delegates elected Dr. Charles William Hoyt, Cincinnati, as Councilor for the First District to succeed Dr. Mayfield.

Dr. Hoyt is a third generation physician and the ninth Doctor Hoyt in his family. His father is Dr. Will Maurice Hoyt, of Hillsboro. His grandfather was the late Dr. William Hoyt, also of Hillsboro.

Dr. Charles Hoyt graduated from Hillsboro High School in 1931, and attended Ohio Wesleyan University. He took his medical training at the Hahnemann Medical College and Hospital of Philadelphia where he received his M. D. degree in 1940. Following internship at Bethesda Hospital in Cincinnati, he engaged in general practice and anesthesiology from 1941 to 1947.



Chas. W. Hoyt, M. D.

Anesthesiology has been his specialty exclusively since 1947, in private practice with Doctors Hoyt, Erb and Associates. His residency in anesthesiology was taken at Hahnemann Medical College and Hospital.

Dr. Hoyt has served the Academy of Medicine of Cincinnati in several ways. He is co-chairman of its Public Relations Committee and has served several years as the Academy's delegate to the OSMA. He served as chairman of the special committee which produced the booklet outlining

the procedures of the OSMA House of Delegates and the responsibilities of individual delegates.

He is a past-president of the Cincinnati Society of Anesthesiologists, and is the 1957-1958 president and former vice-president of the Ohio Society of Anesthesiologists. He is a member of the International Anesthesia Research Society, and of the American Society of Anesthesiologists; also a member of the House of Delegates of the latter organization.

A diplomate of the American Board of Anesthesiologists, he is a fellow of the American College of Anesthesiologists. His local appointments include the attending staff of Bethesda Hospital, where he is director of the Department of Anesthesiology; attending staff of Our Lady of Mercy Hospital, Mariemont; and consultant in anesthesia to the Veterans Administration.

The Hoyts are parents of two children, Judith Ann, age 15, and James William, age 12. His fraternal memberships include Phi Kappa Psi and Phi Alpha Gamma. Other affiliations include memberships in the Hyde Park Country Club, the Episcopal Church and several Masonic bodies including the Royal Arch, Commandery, Scottish Rite and Shrine.

Third District Councilor

The House of Delegates elected Dr. Floyd M. Elliott, Ada, as Councilor for the Third District to succeed Dr. James R. Jarvis, Van Wert, who had served the maximum of three terms on The Council.

Born in Champaign County, the son of the late Dr. Samuel H. Elliott, the new Councilor moved to Ada with the family in 1901. He attended the Ada public schools and graduated from Ohio Northern University. He became a graduate student then at the University of Chicago and obtained his M. D. degree from Loyola University of Chicago, subsequently taking his internship at St. Bernard's Hotel Dieu, Chicago.

Dr. Elliott's devotion to general practice in and around Ada has been supplemented by a variety of civic and organization activities. He has served three years as president of the Harding County Medical Society and has served his local organization in many other ways. For many years he has been delegate of the local Society to the OSMA. His work in behalf of the State Association also dates over many years. He had served on the State Legislative Committee for many years. Also he was a member of the Committee on Federal Legislation.

Dr. Elliott has served two terms as coroner of Harding County and two terms in Ohio House of Representatives. He served 20 years on the Ada Board of Education, 12 of those years as its president. He also is a member of the Ada Public Library Board.

Dr. Elliott's military record dates to the Mexican Border Incident and World War I. A member of the Ohio National Guard for years, he served overseas with the 51st Pioneer Infantry in the grade of captain. He attended the University of Edinburgh, being commanding officer of a U. S. Army student detachment in Scotland. For years he was captain in the U. S. Reserve.



F. M. Elliott, M. D.

A 32nd Degree Mason, Valley of Columbus, he is active in the Blue Lodge of Ada, Chapter of Ada and Council of Kenton. Other memberships include affiliation with the Presbyterian Church, the American Legion, the Veterans of Foreign Wars, and Phi Beta Pi.

Professional affiliations include appointments on the staffs of Harding Memorial Hospital, San Antonio Hospital, Kenton; Lima Memorial Hospital and St. Rita's Hospital at Lima. He is a member of the American Medical Association, American Academy of General Practice, American Association for the History of Medicine, and the New York Academy of Science.

Dr. Elliott is married and his family includes the following sons: Robert B. Elliott, M. D., in practice at Ada and soon to take residency training in pathology at Memphis, Tenn.; Captain John M. Elliott, U. S. Air Force, in Europe and assignments; and Charles S. Elliott, D. D. S., in dental residency at Cincinnati General Hospital. A fourth son, Howard A., was killed in action in Germany.

Past-President

Dr. Robert S. Martin, Zanesville, will serve an additional year on The Council as immediate Past-President.

Treasurer Re-elected

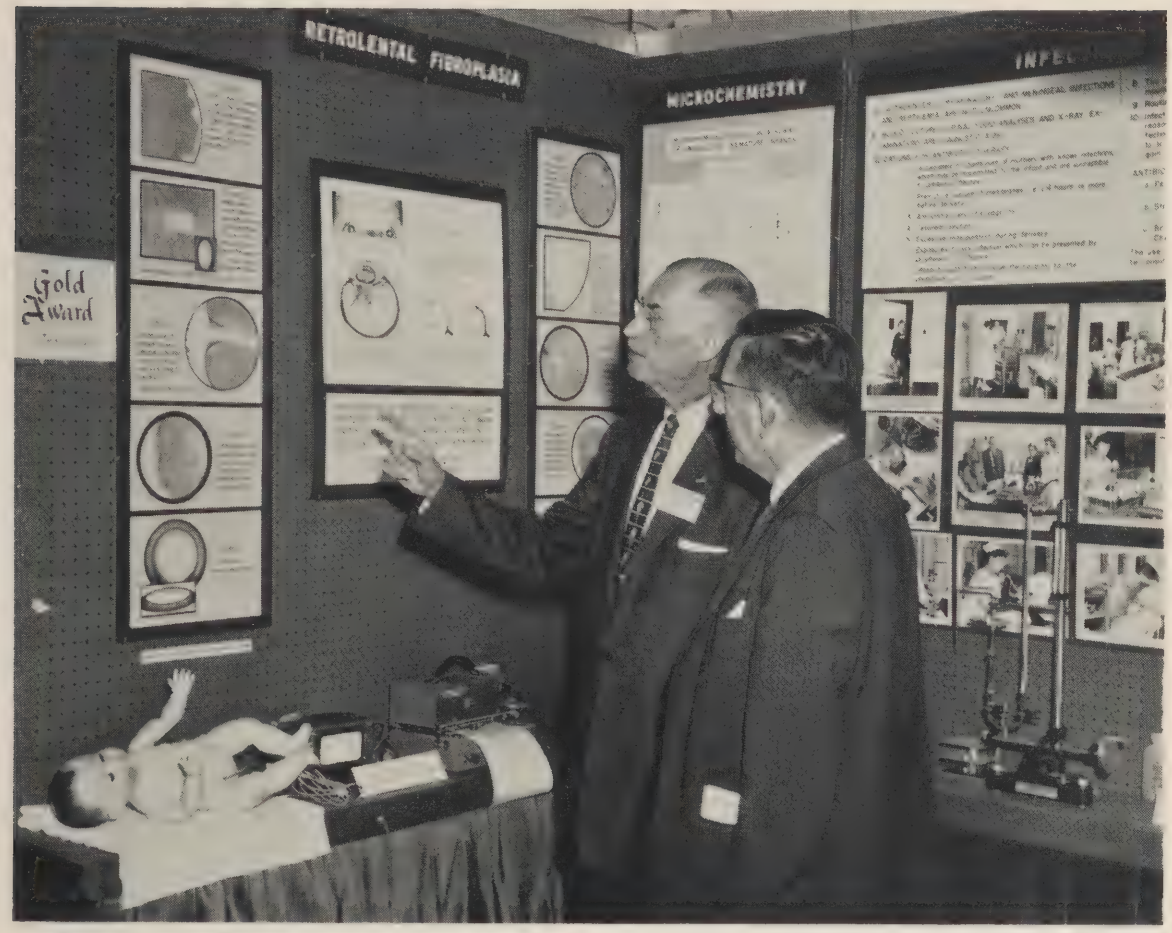
Dr. Geo. J. Hamwi, Columbus, was re-elected to serve a three-year term as Treasurer. He was elected to that office in 1956 to fill two years of the unexpired term of Dr. Richard L. Meiling.

Councilors Re-elected

The following Councilors were re-elected for additional two-year terms:

Dr. George W. Petznick, Cleveland, was re-elected Councilor of the Fifth District. He was elected in 1955 to fill the remaining year of an

AMA President Views Gold Award Exhibit



Examining the Gold Award winning exhibit in the field of education, "Premature Care," are, left, Dr. David B. Allman, President of the AMA, and new OSMA President, Dr. George A. Woodhouse. Sponsors of the exhibit were Drs. Edward A. Wagner, Daniel V. Jones and Carl A. Koch, University of Cincinnati College of Medicine, Department of Pediatrics and the Premature Service Cincinnati General Hospital.

unexpired term and was re-elected in 1956 to his first full term.

Dr. Robert E. Hopkins, Coshocton, was re-elected Councilor of the Seventh District. He was first elected to that office in 1954 and was re-elected in 1956.

Dr. Carter L. Pitcher, Portsmouth, was re-elected Councilor of the Ninth District. He was elected in 1953 to fill one year of an unexpired term and was re-elected in 1954 and 1956.

Dr. H. T. Pease, Wadsworth was re-elected Councilor of the Eleventh District. He was elected to that office in 1954 and re-elected in 1956.

Councilors in the midst of two year terms are: Dr. R. Dean Dooley, Dayton, Second District; Dr. Paul F. Orr, Perrysburg, Fourth District; Dr. C. A. Gustafson, Youngstown, Sixth District; Dr. William D. Monger, Lancaster, Eighth District, and Dr. Edwin H. Artman, Chillicothe, Tenth District.

Cancer Society Man-of-the-Year Award Goes to Dr. Lazzari

Dr. John H. Lazzari, Cleveland physician and chief of staff at Lutheran Hospital, was named Man-of-the-Year by the American Cancer Society and received the award at the meeting of the Ohio Chapter in Cincinnati, April 14. He also is president of the Ohio Surgical Association.

Ohio State Heart Association Announces New Officers

Dr. John W. Martin, Cleveland, was elected president of the Ohio State Heart Association at its recent meeting in Cincinnati. T. Stenson White, also of Cleveland, was elected chairman of the Board.

Other officers elected were Charles W. McCoy Columbus, vice-chairman and treasurer; and Mrs. Carl A. Strauss, Cincinnati, secretary.

Address of the President . . .

Retiring Head of Ohio State Medical Association Speaks Before the First Session of House of Delegates at Annual Meeting in Cincinnati, April 14

By ROBERT S. MARTIN, M. D., Zanesville, Ohio

EACH annual session of the House of Delegates offers an excellent opportunity for us to evaluate our Association. I am certain that most of you are aware of the work of the State Association during the past twelve months. Nevertheless, a brief review will refresh your memory and will, I hope, inspire you to impress upon your respective county medical societies the importance of following through locally.

There is one point which I believe needs clarification and emphasis.

While serving as Councilor, President-Elect and as your President, I have heard this question asked many times in connection with some particular problem or issue:

"What is the Ohio State Medical Association going to do about it?"

Likewise, I have heard many times the question: "What is the American Medical Association going to do about it?"

Obviously, those who have asked this question do not realize that after all the Ohio State Medical Association or the American Medical Association is each of us.

Emphasis on "We"

The question should be "What are we going to do about it?"

In other words, the OSMA or the AMA are merely composites of all of us. Neither is a mystical all-powerful agency with superhuman powers. What they do, can do or will do depends on how we as individual physicians meet our responsibilities in our practice and as members of our local, state and national medical societies.

I hope each of you will carry that message home to the members of your society, especially those who may have a tendency to sit back and expect a few faithful to do all the work.

You are influential members of your county societies. You can play a big part in keeping your societies alert and active and organized in a way that they can be of great assistance to those who are heading up the activities of the State Association. I urge you to give this serious consideration.

Those who have kept up to date by reading the articles and reports which have appeared in *The Ohio State Medical Journal,* know that the Association has been quite busy since our 1957 meeting.

At the regular session of the Ohio General Assembly, our State Legislative Committee and Columbus Office had to follow approximately 100 bills. They were ably assisted by the legislative committees of most of the county medical societies. No law harmful to public health or medical standards was enacted. Outstanding in the session was the enactment of the proposal sponsored by the State Association to make unwanted, stray dogs readily available for medical research.

New Committee on Federal Legislation

Because the job of following the activities of the U. S. Congress has become more important and pressing during the past several years, it was found necessary to create a new committee known as the Committee on Federal Legislation. This committee is headed by Dr. Fred W. Dixon, Cleveland. Last Fall, The Council adopted a statement of policy opposing the enactment of the Forand Bill, (H. R. 9467). This would provide a Federal program of medical and hospital care for aged persons regardless of need. The Council believes this bill is similar to a Federal system of compulsory health insurance. The Council is of the opinion that it is the responsibility of the state and local political subdivisions to look after the needy, including the aged needy, not the Federal Government.

As you all know, our present state program to provide medical and hospital care for the needy aged is far from adequate or satisfactory. Because insufficient funds were appropriated by the last Legislature, the program is failing to meet the needs. The administrative agency found it necessary to reduce the allowances paid to physicians, and others for services to the aged. Even though most physicians are continuing to care for the needy aged under the reduced schedule—some without making charges—your State Association believes this situation should be corrected. Perhaps no solution can be found until the Legislature meets again—in January 1959—but at that time the Association intends to impress upon the law-makers the importance of adequate appropriations with which to meet the medical needs of those receiving aid for aged.

"Votes Made Back Home"

Before leaving matters involving legislation, may I emphasize that there are no persons in Co-

lumbus or Chicago or in Washington who by waving magic wands can bring about the passage or the defeat of legislative proposals. As you have read many times in the OSMA legislative bulletins: "Votes are made back home." This means that your State Legislator or your Congressman looks to his local constituents for advice and guidance. He will be influenced by them as to how he may vote on any given subject. Is your County Medical Society and are the individual members of your County Medical Society meeting their responsibility in this field? Better check on this when you get home.

Third-Party Programs

One of the most vital and one of the most controversial issues before the profession today is that relating to third-party medical care programs. This is not a new issue. Nevertheless because of certain developments within the past several years it has become one of supreme importance to all of us.

I strongly recommend that all members of the Ohio State Medical Association study line by line the excellent statement of policy on third-party medical care plans adopted by The Council on December 15, 1957, on recommendation of the Committee on Medical Services which gave many weeks of study and conference to the question. This statement appeared in its entirety in the January, 1958 issue of *The Journal*. A copy will be found in the House of Delegates packet which will be given to you at the conclusion of this evening's session.

This important statement of policy points out when and how ethical principles may be violated by physicians participating in third-party medical care plans and suggests remedies which may be applied if the facts and circumstances warrant.

A question somewhat similar to the third-party medical care plan issue, namely, corporate practice of medicine, is being studied jointly by the Judicial and Professional Relations Committee and the Committee on Hospital Relations. These committees have already held six meetings. They have conferred with representatives of the Ohio Hospital Association, representatives of various specialty groups and representatives of the Ohio Blue Cross Plans and Ohio Medical Indemnity. The committees are not ready at this time to submit their report but plan to report to The Council at some time during the next several months.

Ohio's Blue Shield

Speaking of Ohio Medical Indemnity, our own medical expense insurance plan, I can report to you that it is completing plans to offer a subscriber contract which will provide larger indemnities and more extensive coverage, including coverage for certain diagnostic services. OMI still holds its rank as the fourth largest Blue Shield plan in the country, covering 2,300,000 citizens of Ohio.

The Council, reaffirming the policy adopted in the Fall of 1956, with regard to the Federal Medicare Program, recently refused to enter into any contract with the Federal Government on Medicare activities, leaving it to each individual Ohio physician to decide for himself whether he desires to participate in the program and accept the scheduled allowances as payment-in-full for services rendered to military dependents.

At the request of the Veterans Administration, The Council has considered a proposal that the formal official contract between the VA and the OSMA, which has been in effect since shortly after the end of World War II, should be dissolved and that the matter of fees be worked out mutually at informal conferences between representatives of the Association and representatives of the VA. The Council has notified the VA of acceptance of this proposal. The details have not as yet been worked out.

I regret that I cannot report that we have been able to secure a more satisfactory schedule of fees for Workmen's Compensation cases. The proposal for adjustment of the fees which we submitted many months ago still is "under advisement" by the Bureau of Workmen's Compensation.

I believe that the Bureau has not been realistic in the way it is handling this matter. In the first place it knows that parts of the fee schedule need upward adjustment as they have not been revised since 1949. Secondly, it should realize that some of the fees allowed are quite inadequate in this period of increased cost of professional practice. We hope that this stalemate will be broken in the near future.

Progress on Maternal Health

The Committee on Maternal Health is carrying on one of our major activities. It drafted and submitted to The Council, which approved, a set of guiding principles for obstetrical care. It is presenting in *The Journal* case histories based on statistical material the committee has collected and analyzed. In the near future it will establish a plan whereby members of the committee can appear before county medical societies to talk about the do's and don'ts of obstetrical care, based on the committee's findings.

A fine report has been compiled by the Committee on Relationship Between Medical Societies and Voluntary Health Agencies. Copies have been

sent to the officers of each county medical society. It presents guides and suggestions in case a county medical society desires to study the question of whether or not the community should have one organization to solicit funds for the various health organizations. You will recall this action was taken following the adoption of a resolution by the House of Delegates last year, endorsing the federated health fund idea in principle.

Other Committee Activities

Another new committee has done a fine piece of work—namely—the Committee on Revision of House of Delegates Procedures. Each of you have been presented with a copy of that committee's report. Those of its recommendations which require changing the By-Laws will be acted upon at this meeting.



Before the final session of the House of Delegates, Dr. Martin (left) is decorated with the Past-President's Pin by Incoming President Woodhouse.

The preceptorship program sponsored by the Committee on Rural Health has become one of the biggest activities of that busy committee. This year approximately forty preceptorships for University of Cincinnati medical students will be available. The committee hopes eventually to make preceptorships available to Ohio State and Western Reserve students, also.

The lectures on small town practice sponsored by this committee for the senior students at Ohio's three medical schools continue to be valuable and popular. This year the lectures were given at a single day's session at the University of Cincinnati and Ohio State University. The attendance far exceeded the number of students reached through the former six-session plan. The old plan of giving a series of lectures was followed at Western Reserve but the attendance has been poor, indicating the one-day plan is more feasible.

Group Life Insurance

Within the next several months, the Association probably will offer members an opportunity to participate in a group life insurance program sponsored by the Association. A committee is preparing to report on this to The Council at its next meeting.

Our Physicians' Placement Service has become one of the most active and valuable of our many activities. It is a real public relations project; also, a program of great help to those starting medical practice in Ohio.

The Association has representatives working on the State Hospital Advisory Council; on an advisory committee to the Division of Aid for the Aged; on an advisory committee to the Division of Public Assistance and on an advisory committee to the Bureau of Vocational Rehabilitation. We are represented on the Governor's Committee on Problems of the Aged; the Ohio Rural Health Council and a variety of other organizations and agencies. I mention these merely to show that every possible effort is being exerted to have the views of the medical profession presented when health programs are planned or carried on.

I could devote considerable more time to reviewing other projects carried on by our committees and concerning the varied activities of our Columbus Office. These references are sufficient, however, to show that the State Association day after day carries a substantial load and is doing a good job of it.

At this point I would like to pay tribute to those who have had a direct part during the past year in helping to establish another good record.

Those Sunday Meetings

Members of most of our committees have spent many days—primarily Sundays—in Columbus on Association business. I wish to thank all of them for their time and efforts. Our entire profession has profited by their work.

Members of The Council continuously spend much time on official business of the Association. All of them merit the sincere thanks of the entire profession.

To you members of the House of Delegates may I express my appreciation and that of the profession for your willingness to give your time and thought to the affairs of our organization.

Then too, we must realize that a great many necessary activities could not have been carried out successfully without the cooperation of officers and committees of the county medical societies

Opening Session of the House of Delegates



This is the speakers' table at the first session of the House of Delegates. Left to right are: Mr. Charles S. Nelson, Executive Secretary; Dr. Geo. J. Hamwi, Treasurer; Dr. George X. Schwemlein, President of the host Cincinnati Academy of Medicine; Dr. Robert S. Martin, OSMA President; Dr. George A. Woodhouse, President-Elect; and Dr. Richard L. Meiling, Immediate Past-President.

who constitute the real foundation of our statewide organization.

Few beside the officers, members of The Council and members of our committees fully realize the amount of work carried on by our headquarters office staff. It is done promptly and well. Their efficiency and personal interest play a real part in the success of our Association. To them I am most grateful for their assistance this year.

First a Citizen

Before concluding, may I say just a few words about how important it is for every doctor to remember that he is not just a doctor—but a doctor and a citizen.

Unfortunately, some physicians—too many I fear—forget that in addition to their duty of looking after the physical and mental health of the people, they have a duty and responsibility to serve their community, state and nation as citizens. To be specific, they have an obligation as citizens to work with others in an effort to solve the social and economic problems which confront all of us.

Too often we hear some physician say that he is too busy to identify himself with community undertakings; too busy to take an active part in political affairs; too uninformed to take a stand on major issues. Frequently, this same physician is too timid to stand up and be counted when vital issues are being debated and voted upon.

Public Service a Tradition

During the early days of this country, members of the medical profession took an active part in moulding public opinion. They were active in the political and economic life of the nation. People looked to them for guidance not only on matters concerning their health, but for advice and counsel on economic, social and political questions. The doctors responded.

Of the fifty-six persons who signed the Declaration of Independence, five were doctors of medicine. They not only had the courage to sign but also had the courage to back up what they signed. This is revealed in the final paragraph of that famous document which reads as follows:

"And for the support of this Declaration, with firm reliance on the protection of Divine Providence, we mutually pledge to each other our lives, our fortunes and our sacred honor."

I would urge all physicians to use their talents and influence in moves to assure better government and in programs for public improvements. Let us be actively and openly for those things which will improve our communities and offer greater opportunities for our children.

As doctors and as citizens we must display the kind of courage displayed by those who signed the Declaration of Independence. The kind of mutual understanding and united action demonstrated by those forefathers is badly needed today, not only in the ranks of the medical profession but throughout our entire society as well.

As I end my term as your president—the greatest honor and privilege it has been my good fortune to enjoy—I leave with you this admonition:

Let us not forget that great heritage handed down to us as doctors—and as citizens.

House of Delegates . . .

Two Lively Sessions Held at 1958 Annual Meeting in Cincinnati; Action Is Taken on Nineteen Resolutions; Officers for 1958-59 Are Named

MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the 1958 Annual Meeting of the Ohio State Medical Association was held in the Restaurant Continental, Netherland Hilton Hotel, Cincinnati, on Monday evening, April 14. There was a dinner with a business session following.

The session was called to order by Dr. George X. Schwemlein, President of the Cincinnati Academy of Medicine. He welcomed the delegates to Cincinnati and then introduced the President, Dr. Robert S. Martin, Zanesville. Dr. Martin then delivered his presidential address. (See pages 770-773 in this issue for Dr. Martin's address.)

Delegates Present Numbered 148

The report of the Credentials Committee was made by Dr. M. D. Shilling, Ashland. It showed 148 officers, councilors and delegates present, as well as 25 alternates and 10 guests.

Following the report of the Credentials Committee, Dr. Martin requested the House of Delegates to stand for a moment of silence in memory of the late Dr. Harry V. Paryzek, Cleveland, former president of the Ohio State Medical Association, and the late Dr. Clarence E. Hufford, Toledo, an alternate delegate from Ohio to the American Medical Association and a member of the Cancer Committee, whose deaths occurred recently.

Auxiliary President Speaks

Dr. Martin then introduced Mrs. V. R. Frederick, Urbana, President of the Woman's Auxiliary to the Ohio State Medical Association. Mrs. Frederick gave an excellent talk on the major activities of the Auxiliary. At the conclusion of her remarks she received a fine ovation from the House of Delegates. (See pages 805-806 in this issue for Mrs. Frederick's address.)

Guests Introduction

Following Mrs. Frederick's talk, President Martin introduced to the House of Delegates the following: John Ray, Columbus, representative of the Student A. M. A. Chapter, Ohio State University College of Medicine; Lee Vesper, Cincinnati, representative of the Student A. M. A. Chapter, University of Cincinnati College of Medicine; and David J. Byrnes, Columbus, executive secretary of the Ohio Academy of General Practice.

On motion duly made, seconded and carried, the minutes of the meetings of the House of Delegates held in connection with the 1957 Annual Meeting in Columbus were approved as published in *The Ohio State Medical Journal*.

Reference Committees

The next order of business was the appointment of Reference Committees by the President. The following were appointed:

Credentials of Delegates — M. D. Shilling, Ashland, chairman; Isador Miller, Urbana; E. J. Meckstroth, Sandusky.

President's Address—J. Martin Byers, Greenfield, chairman; Dale A. Hudson, Piqua; Harry A. Haller, Cleveland; John R. Seesholtz, Canton; Edward W. Harris, Columbus.

Resolutions Committee No. 1—Edmond K. Yantes, Wilmington, chairman; Kenneth D. Arn, Dayton; Donald W. English, Lima; Frank F. A. Rawling, Toledo; Benjamin S. Park, Painesville; John A. Fraser, East Liverpool; B. C. Diefenbach, Martins Ferry; J. L. Kraker, Lancaster; Keith R. Brandeberry, Gallipolis; Philip B. Hardymon, Columbus; N. P. Stauffer, Millersburg.

Resolutions Committee No. 2—John H. Budd, Cleveland, chairman; Charles W. Hoyt, Cincinnati; Ray M. Turner, Springfield; Floyd M. Elliott, Ada; Thomas F. Tabler, Holgate; Asher Randell, Youngstown; Joseph W. Hamilton, Dover; A. C. Ormond, Zanesville; George N. Spears, Ironton; Robert E. Swank, Chillicothe; James T. Stephens, Oberlin.

Tellers and Judges of Election—Robert D. Mansfield, Cincinnati, chairman; George J. Schroer, Sidney; Kenneth E. Bennett, Marietta; H. D. Chamberlain, McArthur; Harry Wain, Mansfield.

Nominating Committee Chosen

The House of Delegates then elected the following Committee on Nominations:

First District—Harry K. Hines, Cincinnati, who was named acting chairman.

Second District—George J. Schroer, Sidney.

Third District—George H. McIllroy, Celina.

Fourth District—Frank F. A. Rawling, Toledo.

Fifth District—Harry A. Haller, Cleveland.

Sixth District—Carl C. Nohe, Akron.

Seventh District—B. C. Diefenbach, Martins Ferry.

Eighth District—James A. L. Toland, Cambridge.

Ninth District—W. M. Singleton, West Portsmouth.

Tenth District—Robert E. Swank, Chillicothe.

Eleventh District—N. J. M. Klotz, Wadsworth.

Resolutions Introduced

Following the election of the Nominating Committee, the House of Delegates then received 19 resolutions which were automatically referred to the Reference Committees on Resolutions. **(See minutes of Second Session of the House of Delegates for the Resolutions and actions thereon.)**

Amendments to By-Laws Approved

Under the item of miscellaneous business, the House of Delegates considered proposed amendments to the Constitution and By-Laws which had been presented for action on authorization of The Council. **By official vote, the House of Delegates approved the following:**

Amendment No. 1

This amendment substitutes wording for Sec. 4, Chapter 1 of the By-Laws pertaining to eligibility for membership in the Ohio State Medical Association. It clarifies the existing section on matters relating to foreign-born applicants for membership.

Sec. 4, Chapter 1 of the By-Laws as amended reads as follows:

Sec. 4. Eligibility. This Association shall consist of one class of members only viz: those members of component societies who have complied with the membership eligibility requirements of this section and whose past and current annual dues and assessments in this Association shall have been received from their respective component societies at the headquarters of this Association.

To be eligible to membership in this Association a person shall possess all of the following qualifications, to-wit:

(a) He must be a citizen of the United States, OR

He must have resided in the United States for at least one year, and he must have filed in an appropriate court of record a declaration of his intention to become a citizen of the United States, which declaration has not been withdrawn.

(b) He must be licensed to practice medicine and surgery by the licensing authority of the State of Ohio, OR

If he is currently serving as a hospital intern or resident within the State of Ohio and is not a member of a medical society of the District of Columbia or of any state or territory of the United States, he must be licensed to practice medicine and surgery by the licensing authority of the District of Columbia or of some state or territory of the United States.

(c) He must hold the degree of doctor of medicine or some foreign degree in medicine regarded by the Council of the Ohio State Medical Association as equivalent thereto.

Amendment No. 2

Amendment No. 2 provides for a new section in Chapter 4 of the By-Laws, relating to the introduction of resolutions in the House of Delegates. It was suggested by the special committee which studied House of Delegates procedure. In effect, it provides resolutions must be filed with the Columbus Office 60 days in advance of the meeting so copies can be distributed to delegates; that no resolution may be introduced otherwise unless consent of two-thirds of the House of Delegates is obtained; that all resolutions must be introduced at the first session of the House of Delegates—a provision implied in the Order of Business but not specifically stated.

The action provides that Section 8 of Chapter 4 of the By-Laws be re-numbered so as to make it read "Section 9," and that the new Section 8 of Chapter 4 of the By-Laws read as follows:

Sec. 8. Resolutions. Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which such action is proposed to be taken; and promptly upon filing of any such resolution the Executive Secretary shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements of filing and transmittal shall have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at such meeting.

The Executive Secretary may cause to be published in *The Journal* in advance of such meeting of the House of Delegates any or all resolutions so filed with him; and upon the direction of the President or the Council the Executive Secretary shall cause to be so published such resolutions as the President or the Council may designate.

No consideration may be given, or any action taken, by the Committee on Resolutions or the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates.

Amendment No. 3

The Committee on Scientific Work had suggested that the committee be enlarged in order to provide more personnel to work on Annual Meeting details. Amendment No. 3 changes Sec. 2 and Sec. 4 of Chapter 9 of the By-Laws enlarging the committee to 10 members.

Sec. 2 and Sec. 4 of Chapter 9 of the By-Laws as amended read as follows:

Sec. 2. Method of Appointment. The standing committees shall be appointed by the President with the approval of the House of Delegates. Each year there shall be appointed one member for a term of five years to each of the following standing committees: Committee on Public Relations and Economics, Committee on Education, and Judicial and Professional Relations Committee; and each year there shall be appointed two mem-

bers for a term of five years to the Committee on Scientific Work. The President shall designate the chairman of each committee from among its members.

Sec. 4. Committee on Scientific Work. The Committee on Scientific Work shall consist of ten members. This committee shall have charge of the general arrangements for the annual meetings of the Association, including the scientific programs both for general sessions and such sections as may be authorized by Council, as well as the scientific exhibits.

On recommendation of this committee the Council shall appoint a general chairman of a Local Committee on Arrangements, who, after consultation with the president of the component society of the county in which the meeting is to be held, shall appoint and organize the personnel of the Local Committee on Arrangements from the members of the component society of such county. Through sub-committees of its choice the Local Committee on Arrangements shall have charge of all local arrangements, including provision of suitable meeting places, subject to the approval of the Committee on Scientific Work.

All receipts from the annual meeting shall be turned over to the Treasurer of this Association. All expenditures must be authorized in advance by the Auditing and Appropriations Committee.

With the advice of the President and subject to approval by Council, the Chairman of the Committee on Scientific Work may appoint such sub-committees as he may deem necessary and designate a chairman for each sub-committee so appointed.

Charters Re-Issued

By official action, the House of Delegates **approved** re-issuance of charters to the Gallia County Medical Society and the Portage County Medical Society, due to the fact that each had lost its original charter.

Standards for Diagnostic Laboratories

A report from the Committee on Public Relations and Economics with regard to a study being made on the feasibility of establishing standards for diagnostic laboratories, as requested by the House of Delegates in a resolution adopted by the House of Delegates at the 1957 Annual Meeting, was received.

The report, which was in the form of a letter from Dr. Frederick P. Osgood, Toledo, chairman of the committee, to Dr. Martin, **was accepted by the House of Delegates by official vote.** It read as follows:

"At the 1957 meeting in Columbus, the House of Delegates adopted Resolution E instructing The Council to appoint a committee to study the matter of establishing qualifications and standards for diagnostic laboratories, this committee to report its recommendations to the 1958 House of Delegates.

"The Council, on September 14-15, 1957, referred this to the Committee on Public Relations and Economics. At a meeting on October 6, 1957, the committee heard from Dr. Robert M. Craig, Dayton, representing the Montgomery County Medical Society; Mr. Leo F. Ey, Chief, Division of Public Health Laboratories, Ohio Department of Health; and Dr. Fred H. Wentworth, Chief, Division of Communicable Diseases, Ohio Department of Health; and also considered a letter from Dr. Merl B. Smith of Toledo.

"After due consideration, the committee referred this information and the problem to a subcommittee consisting of Dr. Horace B. Davidson, Columbus, Chairman; Dr. John B. Hazard and Dr. William J. Sinclair, Cleveland; Dr. Philip B. Wasserman and Dr. Robert J. Ritterhoff, Cincinnati; Dr. Melvin Oosting, Dayton; Dr. William B. Smith, Zanesville; and Drs. Mel A. Davis, Ralph J. Johansmann and Harry L. Reinhart of Columbus.

"This sub-committee spent most of Sunday, December 8, 1957, discussing methods of procedure and concluded that the first requisite was more information concerning the diagnostic laboratories situation in Ohio. A questionnaire was formulated and mailed to all known hospital and clinical laboratories in Ohio early in January, 1958. These laboratories number approximately 350.

"This questionnaire seeks to supply the committee with information regarding the number, types, scopes and facilities of laboratories active in this field, information which heretofore has not been available.

"The response to this request has been gratifying and the questionnaires are now in the process of being tabulated. It is contemplated that the sub-committee very soon will study compilation of the information obtained from these questionnaires.

"I am sure that members of the House of Delegates will appreciate that the matter of establishing qualifications and standards for diagnostic laboratories is no simple problem. Your committee realized that early in its deliberations on Resolution E. It realizes also that it is in the public interest as well as for the good practice of medicine that these laboratories be operated according to the highest standards possible. The best way of securing the cooperation of laboratories in adopting standards which may be agreed upon, must be worked out. This needs very careful consideration.

"The committee regrets that it is not yet in position to present definite recommendations to the 1958 House of Delegates. However, considerable progress has been made in this study and it is our hope that in the near future a feasible plan for solution of the problem can be presented to The Council for its consideration."

The House of Delegates then recessed to meet on Thursday morning, April 17.

As the delegates left the room each was presented with a green folder containing copies of all resolutions, which had been sent to the Columbus office prior to the Annual Meeting, and certain reference material.

MINUTES OF SECOND SESSION

The second and final session of the House of Delegates at the 1958 Annual Meeting was held Thursday morning, April 17, in Parlors L-M-N-O, Netherland Hilton Hotel, Cincinnati, following a breakfast.

Dr. M. D. Shilling, Ashland, chairman of the Credentials Committee, reported that 153 officers, councilors and delegates were in attendance and in addition 12 alternate delegates and six guests.

More Guests Introduced

Before the transaction of business, Dr. Martin introduced two of the out-of-state guests of other associations, namely, Dr. G. W. Slagle, Battle Creek, Michigan, President of the Michigan State Medical Society, and Dr. M. C. Topping, Terre Haute, Indiana, President of the Indiana State Medical Association; also Mr. James Waggener, Indianapolis, Executive Secretary of the Indiana State Medical

Association; and Miss Mary Jane Tompkins, Cleveland, representative of the Student A. M. A. Chapter, Western Reserve University School of Medicine.

Committee on President's Address

Dr. J. Martin Byers, Greenfield, chairman, presented the following report of the Reference Committee on President's Address:

"On behalf of the members of the House of Delegates and the Ohio State Medical Association, the Committee on President's Address wishes to commend Dr. Martin for his well presented and informative address.

"We congratulate Dr. Martin for his sincere belief in the great importance of local medical society action.

"We endorse and wholeheartedly support his reiterated concept that we as individuals must meet our responsibilities in our practices as well as our responsibilities as citizens in our communities.

"We agree with Dr. Martin and The Council on the policy expressed concerning Third Party Medical Care Plans and we urge all members to read that policy statement as published.

"We join with Dr. Martin in commending Ohio Medical Indemnity for the progress it has made. Moreover, we concur in the Association's stand on the Federal Medical Care Program.

"Dr. Martin's report on the accomplishments of the various committees is indeed stimulating and reflects the fine leadership the Association has had during the past year.

"History records the stand that physicians have taken on many important public issues. Now, it is up to us to become informed; to take a more active part in political affairs; and to take a firm stand on current issues. This means we must display united action and mutual understanding—characteristics demonstrated by our forefathers.

"Your committee is happy to have the privilege of commenting on the address of the President of the Woman's Auxiliary to the Ohio State Medical Association.

"Mrs. Frederick's address brought to the Association the broad scope of the Auxiliary's work. It is a dynamic organization and the Association is proud of its accomplishments."

By official action, the report of the committee was approved. Members of the committee, in addition to Dr. Byers, were: Dr. Dale A. Hudson, Piqua; Dr. Harry A. Haller, Cleveland; Dr. John R. Seesholtz, Canton; and Dr. Edward W. Harris, Columbus.

Action on Resolutions

The House of Delegates then took action on the 19 resolutions presented at the first session and the recommendations of the reference committees concerning them, as follows, such committees known as Resolutions Committee No. 1 and Resolutions Committee No. 2 having been chairmanned respectively by Dr. Edmond K. Yantes, Wilmington, and Dr. John H. Budd, Cleveland:

Resolution No. 1

Resolution No. 1, introduced by Dr. J. B. Hazard, Cleveland, read as follows:

WHEREAS, The practice of Pathology is an accepted part of the practice of medicine, with all its requirements of education, licensure, etc., on a par with other medical specialties,

THEREFORE, BE IT RESOLVED:

1. That all indemnities for professional care, including laboratory services, be paid by Medical Mutual or Blue Shield, rather than by Blue Cross.
2. That a plan similar to that recently adopted in Iowa for the transfer of professional services coverage into the Blue Shield contract be accepted by the Ohio Blue Cross organizations.
3. That in any new contractual relationships involving physicians, hospitals and insurance plans, payment for professional services, either in-patient or out-patient, be included under the Blue Shield or Medical Mutual portion of the contract.
4. That pathologists be consulted in any contemplated arrangements between physicians and medical care plans.
5. That immediate action should be taken on this resolution. Recent meetings here and in various other areas in Ohio indicate that unless a plan similar to that in effect in Iowa is adopted, Blue Cross will further expand its services in the field of medical practice in Ohio.

Action on Resolution No. 1

The report of Resolutions Committee No. 2 on Resolution No. 1 was as follows:

"There was a long and thorough discussion of Resolution No. 1 relating to the inclusion of indemnities for the services of pathologists in medical-cost insurance programs. The committee felt that this resolution could be improved through amendments. Therefore, it presents to the House of Delegates the following amended resolution and recommends its adoption."

Amended Resolution No. 1

WHEREAS, The practice of pathology is an accepted part of the practice of medicine, with all its requirements of education, licensure, and professional responsibility, and

WHEREAS, Negotiations are currently being carried on between the Ohio State Medical Association and Ohio Medical Indemnity, Inc., with a view to effectuating plans for the payment of indemnities for services of pathologists by medical-cost insurance,

THEREFORE BE IT RESOLVED, (1) That the House of Delegates urge that these negotiations be continued in the hope of consummation of such plans at the earliest possible date, and (2) That similar negotiations be initiated with other insurance carriers for the payment of indemnities for services of pathologists by medical-cost insurance.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee that amended Resolution No. 1 be adopted was approved.

Resolution No. 2

Resolution No. 2, introduced by Dr. C. R. Jablonoski, Cleveland, read as follows:

WHEREAS, The rising cost of living has in many cases made it extremely difficult for the aged living on pensions or other fixed incomes to meet the costs of medical care, and

WHEREAS, The problem is expected to worsen due to the rising number of aged in our population and due to the constant rise in costs of living, and

WHEREAS, The many attempts to solve the problem

in the Congress of the United States all would open the door to Socialized medicine,

THEREFORE, BE IT RESOLVED, That the House of Delegates request delegates to the American Medical Association National Convention to appoint a committee to explore with the Blue Shield, Blue Cross organizations, and similar insuring agencies, the feasibility of offering an insurance policy for the aged to defray hospital, medical and surgical costs. Said policy should include a provision by which the insured will have paid up all premiums upon reaching the age of 65.

Action on Resolution No. 2

The report of Resolutions Committee No. 1 on Resolution No. 2 was as follows:

"Resolution No. 2 pertaining to insurance for the aged was discussed thoroughly. The principle and problems presented were concurred in. The committee felt that a revision of the final paragraph would implement the intention of the resolution and produce quicker results, since the American Medical Association has already taken steps along this line through the formation of the Joint Council to Improve the Health Care of the Aged."

Amended Resolution No. 2

WHEREAS, The rising cost of living has in many cases made it extremely difficult for the aged living on pensions or other fixed incomes to meet the costs of medical care, and

WHEREAS, The problem is expected to worsen due to the rising number of aged in our population and due to the constant rise in costs of living, and

WHEREAS, The many attempts to solve the problem in the Congress of the United States all would open the door to socialized medicine,

THEREFORE, BE IT RESOLVED, That the House of Delegates instruct our delegates to the American Medical Association to request that the Joint Council to Improve the Health Care of the Aged explore with health insuring agencies the feasibility of offering an insurance contract for the aged to defray hospital, medical and surgical costs, said insurance contract to include a provision by which the insured will have paid up all premiums upon reaching the age of 65.

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee that amended Resolution No. 2 be adopted was approved.

Resolution No. 3

Resolution No. 3, introduced by Dr. Fred R. Kelly, Cleveland, read as follows:

WHEREAS, The laws of the state of Ohio declare specifically that it is unlawful for any persons not certified by the Division of Social Administration, Department of Public Welfare, in any manner knowingly to become a party to the separation of a child from its parent except through a Juvenile Court commitment, and

WHEREAS, Regardless of motive, participation of a physician in the placement of a child for the purpose of adoption is a violation of these laws, and

WHEREAS, The violation of any law, regardless of motive, is contrary to the ethics of any profession enjoying the respect of the community, and

WHEREAS, The public expects members of the medical profession to handle matters of ethical conduct for themselves, and

WHEREAS, The adoption of a child involves the rights and best interest of three parties: the child, the natural parents, and the adopting parents, and requires not only medical but legal and social service to avoid jeopardizing the interests of the three parties, and

WHEREAS, The function of the doctor should be limited to prenatal care, delivery, post-partal care of the mother and medical care of the child and should not include either finding a home for the child, relieving a mother of the responsibility of a child, or satisfying the desires of a childless couple, and

WHEREAS, Every county of Ohio now has legally constituted agencies for the placement of infants for adoption

BE IT THEREFORE RESOLVED, That the Ohio State Medical Association consider it unethical for a physician to participate knowingly in the placement of an infant for adoption except in the manner prescribed by law, namely through persons, associations, or institutions certified by the Department of Public Welfare for that purpose.

Action on Resolution No. 3

The report of Resolutions Committee No. 2 on Resolution No. 3 was as follows:

"Resolution No. 3 relating to adoptions was discussed by many attending the Reference Committee hearings. Based on the testimony presented, the committee formulated an amended resolution which reads as follows, and which the committee recommends be adopted."

Amended Resolution No. 3

WHEREAS, The laws of Ohio provide a well-defined procedure for the legal placement and adoption of children,

BE IT THEREFORE RESOLVED, (1) That the Ohio State Medical Association encourage all its members to familiarize themselves with the laws of Ohio governing, and with the State agencies responsible for, the legal placement and adoption of children; (2) That all County Medical Societies be urged to scrutinize carefully any practice by a physician which may lead to the placement or adoption of any child; (3) That individual physicians acquaint their patients, who may be interested in the matter of adoption, that there is a well-established legal procedure governing placement and adoption.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee that amended Resolution No. 3 be adopted was approved.

Resolutions on Social Security

Three resolutions dealing with Social Security coverage for physicians were introduced—Resolution No. 4, Resolution No. 7, and Resolution No. 18—as follows:

Resolution No. 4

Resolution No. 4, introduced by Dr. Drew J. Arnold, Columbus, read as follows:

WHEREAS, The issue of Federal Social Security for Doctors of Medicine is currently under active consideration and

WHEREAS, There is a widespread lack of understand-



Three Facets of the Annual Meeting

Three Phases of the Annual Meeting Activities Are Shown.
Top Photo: A view in the Pavillon while one of the scientific programs was in progress.
Middle Photo: A scene during the Annual Banquet, showing some of those at the speakers' table.
Bottom Photo: The first session of the House of Delegates, showing Dr. Martin giving the Presidential Address.

ing among members of the profession as to the actual implications of inclusion and

WHEREAS, Further educational efforts should be carried out to familiarize the profession at large with the serious flaws in the plan as relates to inclusion of physicians and

WHEREAS, Acquiesence to inclusion is not only irrevocable forever but will remove one of the last important barriers to the socialization of the medical profession

THEREFORE BE IT RESOLVED, That this House of Delegates of the Ohio State Medical Association in convention assembled this seventeenth day of April reaffirm the previous action of the Ohio State Medical Association opposing the inclusion of Doctors of Medicine in Social Security, commend similar action by the House of Delegates of the AMA and recommend to the President of the OSMA that prompt and vigorous measures be instituted for familiarizing the membership with the danger to the profession of such inclusion and with the financial unsoundness of the plan.

Resolution No. 7

Resolution No. 7, introduced by Dr. Neil Millikin, Hamilton, read as follows:

WHEREAS, The Butler County Medical Society voted, by secret ballot, April 1957, in favor of coverage for self-employed physicians under the existing Social Security Act (Federal Insurance Contributions Act) by a vote of 90 to 36, and

WHEREAS, Impartial surveys and analysis have indicated that such coverage offers many of our profession a desirable addition to their present Insurance and Retirement programs at a disproportionately low cost, and

WHEREAS, A substantial number of Ohio physicians are, by reason of present or past employment, already enjoying the benefits of Social Security coverage, and

WHEREAS, There is evidence of a change of sentiment by the medical profession towards social security coverage, and

WHEREAS, Some now feel that the advantages of such coverage outweigh the disadvantages, and

WHEREAS, It is felt necessary to maintain an accurate and uptodate expression of the desires of Ohio physicians,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association conduct frequent polls of its membership on the question of Social Security coverage and that the results of such efforts be communicated to the membership and the American Medical Association.

Resolution No. 18

Resolution No. 18, introduced by Dr. John J. Grady, Cleveland, read as follows:

WHEREAS, A majority of the physicians in Cuyahoga County have expressed a desire to be included in the Social Security program, and

WHEREAS, The Ohio State Medical Association and the American Medical Association have been on record as opposing such a move,

THEREFORE BE IT RESOLVED, That (1) the House of Delegates of the Ohio State Medical Association be polled on this question, and (2) the results of this poll indicating the number of votes in favor of and opposed to the inclusion of physicians in the Social Security program be made a matter of record and transmitted to the Board of Trustees of the American Medical Association and to the Ways and Means Committee of the United States House of Representatives.

Action on Social Security Resolutions

The report of Resolutions Committee No. 2 on the Social Security resolutions was as follows:

"After prolonged hearing and based on the testimony presented by those interested in these resolutions, the committee presents to the House of Delegates for consideration, a composite Substitute Resolution No. 4 which reads as follows:"

Substitute Resolution No. 4

WHEREAS, The inclusion of doctors of medicine in the Federal Social Security program is currently under consideration, and

WHEREAS, The Ohio State Medical Association and the American Medical Association are now on record as opposing the inclusion of physicians in the Social Security program, and

WHEREAS, A considerable number of physicians in Ohio have expressed a desire to be included in the Social Security program, and

WHEREAS, It is desirable to ascertain the current sentiment of all members of the Ohio State Medical Association on this question,

THEREFORE BE IT RESOLVED, That (1) the individual members of the Ohio State Medical Association be polled by the Association on the question as to whether they favor or oppose the inclusion of physicians in the Federal Social Security program, and (2) the results of this poll showing the number of votes in favor of and in opposition to such inclusion be made a matter of record and transmitted to the House of Delegates of the American Medical Association, and

BE IT FURTHER RESOLVED, That such poll be conducted prior to the 1958 interim session of the American Medical Association so that the results of such poll can be submitted to the House of Delegates of the American Medical Association at said meeting.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee that Substitute Resolution No. 4 be approved was adopted.

Resolution No. 5

Resolution No. 5, introduced by Dr. Robert M. Inglis, Columbus, read as follows:

WHEREAS, The Ohio State Medical Association has for several years endorsed the Essay Contest for High School Students, of the Association of American Physicians and Surgeons (Titles: The Advantages of Private Medical Care or The Advantages of The American System of Free Enterprise) and

WHEREAS, The need for such a contest seems to increase each year and

WHEREAS, This contest has received increasing sponsorship throughout Ohio by the Auxiliaries of the County Medical Societies and

WHEREAS, Such approval by the House of Delegates of the Ohio State Medical Association is essential to the continuing sponsorship by the State and local auxiliaries

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association for 1958 go on record as approving this contest and recommending it to the Woman's Auxiliary for sponsorship.

Action on Resolution No. 5

The report of Resolutions Committee No. 1 on Resolution No. 5 was as follows:

"Resolution No. 5 endorses the essay contest of the Association of American Physicians and Surgeons. The committee recommends that Resolution No. 5 be adopted as presented."

On motion by Dr. Yantes, seconded and

carried, the recommendation of the committee endorsing Resolution No. 5 was approved.

Resolution No. 6

Resolution No. 6, introduced by Dr. John R. Seesholtz, Canton, read as follows:

WHEREAS, The Ohio State Medical Society's delegates have attempted to bring about the passage of Resolution 20 of American Medical Association, as directed by the Ohio State Medical Association

WHEREAS, The establishment of a National Medical Research Foundation by the American Medical Association has been accomplished

WHEREAS, the full passage of Resolution 20 will be necessary to make the American Medical Association Research Foundation everything the Ohio State Medical Association resolution desired

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as continuing to further the successful accomplishment and passage of Resolution 20 by the House of Delegates of the American Medical Association.

Action on Resolution No. 6

The report of Resolutions Committee No. 2 on Resolution No. 6 was as follows:

"Many appeared before our committee to discuss Resolution No. 6 pertaining to the National Medical Research Foundation of the American Medical Association. After hearing the debate and listening to testimony, the committee drafted a substitute resolution reading as follows, and which the committee recommends be adopted by this House of Delegates."

Substitute Resolution No. 6

WHEREAS, The establishment of a National Medical Research Foundation by the American Medical Association has been accomplished,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association go on record as continuing the support of this Foundation.

On motion by Dr. Budd, seconded and carried, the recommendation of the committee approving Substitute Resolution No. 6 was adopted.

Resolution No. 8

Resolution No. 8, introduced by Dr. James D. Phinney, Cincinnati, read as follows:

WHEREAS, The present Constitution and Bylaws of the Ohio State Medical Association, Chapter II, Section I, specify that a Doctor of Medicine must be retired from the active practice of medicine to be eligible for exemption of annual dues, and

WHEREAS, It is felt that a member in good standing of this Society, who has attained the age of seventy (70) years, should be eligible for exemption from the annual dues of this Society regardless as to whether or not he is engaged in the active practice of medicine,

THEREFORE BE IT RESOLVED, That Chapter II, Section I, of the Bylaws of the Ohio State Medical Association be amended by the insertion of a third paragraph to read as follows:

"Provided also that a Doctor of Medicine who is a member in good standing of this Association, at the time of his attainment of the age of seventy (70) years, shall be exempt from the payment of dues and assessments in this Association, provided he requests such exemption and such request is approved, in writing, by the Secretary-Treasurer of his component Society."

Action on Resolution No. 8

The report of Resolutions Committee No. 2 on Resolution No. 8 was as follows:

"Factual information with respect to the possible effect of Resolution No. 8, should it be adopted, was obtained by the committee from officials of the State Association. After evaluating this evidence the committee recommends that Resolution No. 8 not be adopted for the following reasons:

"1. The By-Laws now provide that doctors retired from practice because of age, or because of disability regardless of age, may continue as members of the Ohio State Medical Association without the payment of annual dues.

"2. Statistics presented to the committee indicate that between 800 and 1,000 members 70 years of age or over are in active practice and would be eligible for this exemption, which would mean a loss of income to the Association of approximately $20,000 to $25,000 per year.

"3. That this loss of income would impair the functions of the Association or would require an increase in the annual dues."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee that Resolution No. 8 should not be approved was adopted.

Resolution No. 9

Resolution No. 9, introduced by Dr. Richard B. Homan, Cincinnati, read as follows:

WHEREAS, The Division of Aid For The Aged, Department of Public Welfare, is experiencing difficulty in administering its medical program, and

WHEREAS, This program has received widespread criticism, and

WHEREAS, The medical profession is desirous of assisting this agency of the State of Ohio to function in an efficient manner,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association offer the services of a committee to deliberate with the Division of Aid For The Aged, Department of Welfare of the State of Ohio, and to propose the formation of a sound, equitable, and workable program, including a recommendation for the adoption of an adequate medical fee schedule.

Action on Resolution No. 9

The report of Resolutions Committee No. 1 on Resolution No. 9 was as follows:

"Resolution No. 9 on the Ohio Aid for the Aged Program was approved with slight modifications. It was pointed out that the Committee on Medical Services of the Ohio State Medical Association is at work on this problem and

is planning to continue its good work, pointing toward the next session of the Ohio Legislature."

Amended Resolution No. 9

WHEREAS, The Division of Aid for the aged, Department of Public Welfare is experiencing difficulty in administering its medical program, and

WHEREAS, This program has received widespread criticism, and

WHEREAS, The medical profession is desirous of assisting this agency of the State of Ohio to function in an efficient manner.

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association offer the services of a committee to deliberate with the Division of Aid for the Aged, Department of Welfare of the State of Ohio, and to propose the formation of a sound, equitable, and workable program.

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee endorsing Amended Resolution No. 9 was approved.

Resolution No. 10

Resolution No. 10, introduced by Dr. Daniel V. Jones, Cincinnati, read as follows:

WHEREAS, The Ohio State Medical Association deemed it necessary to adopt and promulgate a policy regarding the determination of the ethical status of physicians participating in third party medical plans, and

WHEREAS, Local county medical societies may be compelled to use the policy presented before governmental agencies and courts of law, and

WHEREAS, The general principle of free choice of a physician by a patient has been upheld by the Ohio State Medical Association and the American Medical Association,

THEREFORE BE IT RESOLVED, That the words "a reasonable degree of" be deleted from conclusions and recommendations on page 12, paragraph 2 (e), of the Statement of Policy, thereby causing paragraph 2 (e) to read "Deny to the members of the community in which the physician practices, free choice of a physician or physicians."

Action on Resolution No. 10

The report of Resolutions Committee No. 1 on Resolution No. 10 was as follows:

"Resolution No. 10, concerning free choice of physician, was discussed at considerable length. It was pointed out that the wording of the Council's statement of policy on third party medical care plans corresponds with the American Medical Association policy adopted in 1927 and which has been upheld in many instances since that time. The committee felt that a change in the wording of the Ohio State Medical Association policy statement as suggested by the resolution would produce a rule which probably would be unenforceable and would tend to make commonplace and acceptable situations unethical. Therefore, it was the opinion of your committee that at this time there should be no change in the policy statement of the Ohio State Medical Association in order to avoid a conflict with the American Medical Association policy as set forth by the Judicial Council of the A. M. A. and carrying the official approval of the House of Delegates of the A. M. A.

"For these reasons your committee recommends that Resolution No. 10 not be adopted."

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee that Resolution No. 10 not be approved was adopted.

Resolution No. 11

Resolution No. 11, introduced by Dr. J. Harold Kotte, Cincinnati, read as follows:

RESOLVED, That the Ohio State Medical Association indicates its approval of the Cornell Research Crash Program as it has been accepted by the Department of Highway Safety and the Ohio State Patrol of the State of Ohio, and approved by the Ohio Committee on Trauma of the American College of Surgeons.

Action on Resolution No.11

The report of Resolutions Committee No. 1 on Resolution No. 11 was as follows:

"Resolution No. 11 pertains to the Automotive Crash Injury Research Project of the Department of Public Health and Preventive Medicine of the Cornell University Medical School, New York.

"The committee favors the resolution and suggests the adoption of a second paragraph. The resolution, as amended, would read as follows:"

Amended Resolution No. 11

RESOLVED, That the Ohio State Medical Association indicates its approval of the Automotive Crash Injury Research Project of the Department of Public Health and Preventive Medicine of the Cornell University Medical School, New York, New York, as it has been accepted by the Ohio Department of Highway Safety and the Ohio State Patrol of the State of Ohio, and approved by the Ohio Committee on Trauma of the American College of Surgeons.

BE IT FURTHER RESOLVED, That the President appoint a special committee to implement the work of the above-named organizations and to further the traffic safety program of the State of Ohio.

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee endorsing Amended Resolution No. 11 was approved.

Resolution No. 12

Resolution No. 12, introduced by Dr. W. R. Agricola, Newcomerstown, read as follows:

WHEREAS, There has arisen a problem to the physicians of Ohio relative to their status in regards to payment for their services to certain individuals covered by third-party payment plans and,

WHEREAS, The principle of indemnity payments has been repeatedly endorsed by the House of Delegates of the Ohio State Medical Association and the Council of the Ohio State Medical Association and,

WHEREAS, The House of Delegates of the Ohio State Medical Association by action at the Annual Meeting in 1956 affirmed that it was not the province of a third-

Councilors and Guests at the Banquet







Above are three groups at the Banquet, Showing Councilors, Past-Presidents and distinguished guests.

party to qualify any physician as to his ability or professional standing and,

WHEREAS, Certain third-party groups, notably the Welfare and Retirement Fund of the United Mineworkers of America, have restricted their payments to individuals and hospitals selected by the third-party without the recipient of the services having any voice in such selection and,

WHEREAS, Such action as detailed in the paragraph next above prohibits many qualified physicians and hospitals from rendering care to individuals entitled to care under such plans and, more importantly, tends to lower the quality and availability of medical care to which such individuals are entitled,

THEREFORE BE IT RESOLVED, That this House of Delegates suggest that a plan be evolved whereby the third-party deal directly with the recipient of any benefits and that the beneficiary deal directly with the physician or hospital involved and,

That such a plan be effective for any legally licensed physician in Ohio and any hospital accredited by the Joint Commission on Accreditation of Hospitals and,

That a copy of this resolution be sent to Dr. Warren Draper, Administrator of the Welfare and Retirement Fund of the United Mineworkers of America, with a request that he consider it and make reply and comments to our President, Dr. George Woodhouse, 79 East State St., Columbus, Ohio.

Action on Resolution No. 12

The report of Resolution Committee No. 1 on Resolution No. 12 was as follows:

"The committee, in considering Resolution No. 12 on the United Mine Worker Medical Care program and similar third party plans, presented by the Coshocton County Medical Society, accepted the five "Whereas" paragraphs as written. The resolved section was amended to read as follows:

"THEREFORE, BE IT RESOLVED, That this House of Delegates suggests that a plan be evolved by a joint committee from the United Mine Workers and the Ohio State Medical Association whereby the third party shall deal directly with the recipient of any benefits and such recipient shall deal directly with the physician involved; that such a plan be effective for any legally licensed physician in Ohio; and that a copy of this resolution be sent to Dr. Warren Draper, Administrator of the Welfare and Retirement Fund of the United Mineworkers of America, with a request that he consider it and make reply and comments to our President, Dr. George Woodhouse, 79 East State St., Columbus, Ohio."

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee supporting Amended Resolution No. 12 was approved.

Resolution No. 13

Resolution No. 13, introduced by Dr. Lynne E. Baker, Dayton, read as follows:

WHEREAS, The 250,000 potentially toxic, brand name chemical products, available for farm, home and industrial use, result annually in over 125,000 accidental poisonings, more than 1,000 of which are fatal; and

WHEREAS, Many of the larger metropolitan areas have established and successfully demonstrated the value of Poison Control Centers in reducing the toll from accidental poisonings; and

WHEREAS, Their high cost prohibits the establishment of adequate Poison Control Centers in all but the large metropolitan areas; therefore,

RESOLVED, That the Ohio State Medical Association Council be instructed to appoint a Poison Control Committee whose functions shall include:

(1) A study to determine the feasibility of a single, Central Poison Control Center for Ohio to provide (a) authorized persons and institutions in all of Ohio's 88 counties with information on poisons and poisonings not available locally, such information to be made available by telephone on a 24-hour-a-day basis, (b) assistance to such persons and institutions in setting up adequate local facilities for treatment of poison cases and in keeping up-to-date information files on the more common poisons;

(2) Initiation of a state-wide educational program on prevention of accidental poisoning;

(3) Recommending of legislation for accurate and uniform labeling;

(4) Establishing liaison with hospitals and pharmaceutical associations, drug manufacturers, safety councils, health departments and other government agencies in order to develop support, financial and otherwise, for a comprehensive, state-wide poison control program.

Action on Resolution No.13

The report of Resolutions Committee No. 2 on Resolution No. 13 was as follows:

"The committee believes that the intent of Resolution No. 13 on the subject of poison controls is commendable. After listening to testimony on this proposal, the committee drafted a substitute resolution reading as follows:"

Substitute Resolution No. 13

WHEREAS, The many thousands of brand name chemical products available for farm, home and industrial use, result in many accidental poisonings, a considerable number of which are fatal, and

WHEREAS, Many of the larger metropolitan areas have established and successfully demonstrated the value of Poison Control Centers in reducing the toll from accidental poisonings; and

WHEREAS, The high cost of establishing and maintaining adequate poison control centers prohibits this activity in any but the large metropolitan areas,

THEREFORE BE IT RESOLVED, That the Council of the Ohio State Medical Association appoint a Poison Control Committee whose functions shall include:

(1) The formulation of plans for the establishment of a single Central Poison Control Center for Ohio which shall provide authorized persons and institutions in all of Ohio's 88 counties with information, not available locally, on poison and poisonings, such information to be made available by telephone on a 24-hour-a day basis.

(2) The initiation of a state-wide educational program on prevention of accidental poisoning.

(3) A study of the need for additional legislation in Ohio for accurate and uniform labeling of products as to content, etc.

(4) The securing of cooperation of hospital and pharmaceutical associations, drug manufacturers, safety councils, health departments and other interested groups in order to develop support for a comprehensive, state-wide poison control program.

On motion by Dr. Budd, seconded and carried, the recommendation of the Committee en-

dorsing Substitute Resolution No. 13 was approved.

Resolution No. 14

Resolution No. 14, introduced by Dr. B. C. Diefenbach, Martins Ferry, read as follows:

WHEREAS: 1. Ohio State University is a tax supported institution.

2. Members of the United Mine Workers union are covered by full medical insurance even for office visits to specialists.

3. There are numerous tax supported welfare organizations in the state, where medical services are paid by direct taxation, that could furnish charity patients for residency training.

THEREFORE, BE IT RESOLVED:

1. That the Ohio State Medical Association goes on record as opposing free, or reduced rate charges, to members of the United Mine Workers in the ophthalmology department of Ohio State University.

2. That the council be instructed to take whatever steps are necessary to see that this condition is changed so that the taxpayer's money is not being used needlessly and to see that this does not happen again in any form in any state supported institution.

Action on Resolution No. 14

The report of Resolutions Committee No. 1 on Resolution No. 14 was as follows:

"Resolution No. 14 pertains to reduced fees for United Mine Worker patients receiving services at the Ohio State University Health Center. The committee felt that even though the situation which inspired this resolution has in most part been resolved, that the intent of the resolution, for future instances of this kind, should be published and endorsed. Resolution No. 14 after much discussion, was rewritten to read as follows:"

Amended Resolution No. 14

WHEREAS, There are numerous tax supported welfare organizations in the state where medical services are paid by direct taxation.

THEREFORE, BE IT RESOLVED, That all health insurance carried by or for the patient be considered by all tax-supported institutions in evaluating the means test for medical or hospital care provided through the facilities of such tax-supported institutions.

Dr. Yantes moved the adoption of Resolution No. 14, as amended by the committee. This motion was seconded. Following a discussion Dr. Thomas D. Kinney, Cleveland, moved that the report of the committee on Resolution No. 14 and the resolution be laid on the table. This motion was seconded. The motion to table lost. The House of Delegates then, by official vote, approved Amended Resolution No. 14.

Resolution No. 15

Resolution No. 15, introduced by Dr. B. C. Diefenbach, Martins Ferry, read as follows:

WHEREAS, Each county medical society is a component part of the parent Ohio State Medical Association and should receive aid and support from this parent organization.

THEREFORE, BE IT RESOLVED, That at any time any county society's action is appealed to the Ohio State Medical Association or that action is challenged as being illegal it shall be mandatory for the state officers to notify the county society so charged immediately.

Action on Resolution No. 15

The report of Resolutions Committee No. 1 on Resolution No. 15 was as follows:

"The committee approved the acceptance of Resolution No. 15, which requests that the officers of the Ohio State Medical Association shall promptly notify a county medical society concerning any appeal or similar communication which may be filed with the State Association, challenging the legality of any action taken by such county society."

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee endorsing Resolution No. 15 was approved.

Resolution No. 16

Resolution No. 16, introduced by Dr. John A. Carter, Middletown, read as follows:

WHEREAS, The Board of Health of a General Health District in the State of Ohio is a legislative body with powers to spend public funds and to adopt regulations binding upon all the citizens of the district, and

WHEREAS, The revised Code of the State of Ohio places responsibility for the election of Health Board members in the hands of township trustees and mayors of villages, who do not necessarily possess the technical and professional qualifications necessary for supervising matters of public health, or selecting competent members for a Board of Health, and

WHEREAS, Only one member of the Board of Health is required to be a physician, and the other four members are not required to possess any qualifications beyond that of citizenship, and

WHEREAS, The Butler County Medical Society on January 22, 1958 passed a resolution urging modification of the Hughes-Griswold Act to provide for selection of qualified members of the County Board of Health,

THEREFORE BE IT RESOLVED, That Council of the Ohio State Medical Association be requested to submit recommendations to the Legislature of the State of Ohio which will abolish the present Advisory Council and rescind other relative sections of the Revised Code of the State of Ohio which places the control of the election of Health Board members in the hands of village mayors and township trustees.

BE IT FURTHER RESOLVED, That legislative measures be enacted into law that would authorize independent esablishment of Boards of Health with specific requirements for the technical and professional qualifications of members who are required to deal with matters of public health.

Action on Resolution No. 16

The report of Resolutions Committee No. 1 on Resolution No. 16 was as follows:

"The committee was in sympathy with the intent of Resolution No. 16. However, inasmuch as the resolution involves many intricate problems, including legal, legislative and political matters, the committee believes the resolution

should be carefully studied before steps are suggested for carrying out its provisions. Therefore, the committee recommends that Resolution No. 16 be referred to The Council of the Ohio State Medical Association for study and action."

On motion by Dr. Yantes, seconded and carried, the recommendation of the committee with regard to Resolution No. 16 was approved.

Resolution No. 17

Resolution No. 17, introduced by Roger A. Peatee, Bowling Green, read as follows:

WHEREAS, In order to produce, process and preserve foodstuffs for human consumption, it is necessary to bring into the State of Ohio migrant laborers; and

WHEREAS, These people do not reside in the State of Ohio or the various counties of the state long enough to become legal residents; and

WHEREAS, They need, from time to time, medical care rendered by physicians and hospitals of Ohio; and

WHEREAS, They often do not, on their own volition. reimburse the said physicians or hospitals for medical care,

BE IT RESOLVED, That by law, all migrant laborers and their dependents be insured to cover the cost of medical care while in the State of Ohio; and

BE IT FURTHER RESOLVED, That all employers of migrant labor be required by law to ascertain that such insurance is available, in lieu thereof, be responsible for all medical care of migrant laborers and their dependents; and that every possible means be used to make this the law of the State of Ohio.

Action on Resolution No. 17

The report of Resolutions Committee No. 2 on Resolution No. 17 was as follows:

"After hearing evidence on this resolution relating to migrant laborers, the committee is in agreement that a problem exists and that efforts should be made to try to find a solution. However, because of the many questions involved in setting up a proper program, the committee felt that the matter should be studied thoroughly. For that reason, the committee recommends that the resolution be referred to The Council for appropriate study and prompt action."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee with respect to Resolution No. 17 was approved.

Resolution No. 19

Resolution No. 19, introduced by Dr. Asher Randell, Youngstown, read as follows:

WHEREAS, There is no established state-wide physicians welfare fund, and

WHEREAS, There is no established state-wide low cost program offering retirement income to physicians, and

WHEREAS, There is a definite need for the establishment of such a program in order to provide senior physicians and their families with security sufficient to preclude the reduction of their standard of living, beyond reason.

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association appoint or charge an already appointed committee to formulate a workable plan providing for a physician welfare fund and a retirement income program for members of the Ohio State Medical Association. This plan should emphasize a state-wide physician participation at a low cost basis. All avenues of conservative investment should be explored including group life insurance, variable annuities, and mutual fund shares. A voluntary plan should be set up, compulsory to a degree, in order to enforce savings for the development of a welfare fund and a retirement income program. It would operate under the auspices of the Ohio State Medical Association. Also, that the committee investigate the feasibility of the Ohio State Medical Association underwriting, as an agent, such a program. That consideration be given to the possibility of incorporating the cost of the program into the regular state membership dues. That the state membership dues be appropriately increased to cover the cost of this savings plan, and if necessary, dues to the Ohio State Medical Association be paid on a monthly basis in order to reduce the financial strain of such a program. That a study of the tax status of organizational dues paid to the Ohio State Medical Association be made including that part of the assessment placed in the welfare and retirement income fund.

Action on Resolution No. 19

The report of Resolutions Committee No. 2 on Resolution No. 19 was as follows:

"Because of the broad scope of the subject of Resolution 19 and the many problems which it entails, the committee recommends that this resolution be referred to The Council of the Ohio State Medical Association for study and report back at the next annual session of the House of Delegates."

On motion by Dr. Budd, seconded and carried, the recommendation of the committee with respect to Resolution No. 19 was approved.

Dr. Yantes and Dr. Budd thanked the members of their committees for their efficient work and for having given the resolutions such careful scrutiny. The House of Delegates approved these sentiments by prolonged applause. Members of the two reference committees on resolutions were:

Resolutions Committee No. 1—Edmond K. Yantes, Clinton County, chairman; Kenneth D. Arn, Montgomery County; Donald W. English, Allen County; Frank F. A. Rawling, Lucas County; Benjamin S. Park, Lake County; John A. Fraser, Columbiana County; B. C. Diefenbach, Belmont County; J. L. Kraker, Fairfield County; Keith R. Brandeberry, Gallia County; Philip B. Hardymon, Franklin County; N. P. Stauffer, Holmes County.

Resolutions Committee No. 2—John H. Budd, Cuyahoga County, chairman; Charles W. Hoyt, Hamilton County; Ray M. Turner, Clark County; Floyd M. Elliott, Hardin County; Thomas F. Tabler, Henry County; Asher Randell, Mahoning County; Joseph W. Hamilton, Tuscarawas County; A. C. Ormond, Muskingum County; George N.

Spears, Lawrence County; Robert E. Swank, Ross County; James T. Stephens, Lorain County.

Election of President-Elect

The House of Delegates then proceeded with the nomination and election of the president-elect.

Dr. Frank F. A. Rawling, Toledo, placed in nomination the name of Dr. Paul F. Orr, Perrysburg, currently serving as Councilor of the Fourth District, for the office of president-elect. The nomination was seconded by Dr. John H. Budd, Cleveland.

The name of Dr. Frank H. Mayfield, Cincinnati, currently serving as Councilor of the First District, was placed in nomination by Dr. Charles W. Hoyt, Cincinnati. The nomination was seconded by Dr. Kenneth D. Arn, Dayton.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the Committee on Tellers and Judges of Elections instructed to distribute ballots to members of the House of Delegates.

Following the tabulation of the ballots, Dr. George J. Schroer, Sidney, acting chairman of the committee, reported that the House of Delegates had voted as follows: Dr. Mayfield, 82 votes and Dr. Orr, 71 votes.

Dr. Martin declared Dr. Mayfield as having been elected to the office of president-elect. Dr. Mayfield was escorted to the rostrum and officially introduced to the House. He thanked the House of Delegates for the high honor and pledged his complete efforts on behalf of the Association during the succeeding three years while serving as president-elect, president and past-president.

Election of Councilors

The Committee on Nominations then reported, the report being presented by Dr. Harry K. Hines, Cincinnati, chairman of that committee.

The committee placed in nomination for members of The Council the following: **First District**—Dr. Charles W. Hoyt, Cincinnati, to succeed Dr. Frank H. Mayfield; **Third District**—Dr. Floyd M. Elliott, Ada, to succeed Dr. James R. Jarvis, Van Wert, who had served the constitutional limit of three consecutive terms on The Council and therefore, was ineligible for re-election; **Fifth District**—Dr. George W. Petznick, Cleveland; **Seventh District**—Dr. Robert E. Hopkins, Coshocton; **Ninth District**—Dr. Carter L. Pitcher, Portsmouth; **Eleventh District**—Dr. H. T. Pease, Wadsworth.

There being no nominations from the floor the nominations were closed and the secretary instructed to cast the unanimous ballot of the House of Delegates for Doctors Hoyt, Elliott, Petznick, Hopkins, Pitcher and Pease. This was done and the President declared them elected for a term of two years, 1958-1959 and 1959-1960.

Election of Treasurer

The committee placed in nomination for the office of Treasurer the name of Dr. Geo. J. Hamwi, Columbus, the incumbent.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Hamwi as treasurer for a term of three years—1958-1959, 1959-1960, 1960-1961. This was done and the President declared Dr. Hamwi elected.



Dr. George A. Woodhouse is shown addressing the House of Delegates as he assumed Presidency of the Association.

AMA Delegates and Alternates

Delegates and Alternates to the American Medical Association to serve for a term of two years beginning January 1, 1959, were nominated by the Committee on Nominations as follows:

Dr. Charles L. Hudson, Cleveland, delegate, and Dr. H. T. Pease, Wadsworth, alternate.

Dr. Carl A. Lincke, Carrollton, delegate, and Dr. Robert S. Martin, Zanesville, alternate.

Dr. George A. Woodhouse, Pleasant Hill, delegate, and Dr. R. Dean Dooley, Dayton, alternate.

Dr. Herbert B. Wright, Cleveland, delegate, and Dr. Fred W. Dixon, Cleveland, alternate.

There being no further nominations, on motion duly made and seconded, the nominations were closed and the secretary was instructed to

cast the unanimous ballot for the foregoing for the office of delegate and the office of alternate to the American Medical Association for two-year terms starting January 1, 1959.

The Nominating Committee also placed in nomination the name of Dr. H. T. Pease, Wadsworth, as an alternate delegate to the A. M. A. to serve the unexpired term of the late Dr. C. E. Hufford, Toledo, ending December 31, 1958.

There being no further nominations, on motion duly made, seconded and carried, the nominations were closed and the secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Pease as alternate delegate to serve the unexpired term of the late Dr. Hufford, ending December 31, 1958.

Dr. Hines thanked the members of his committee for their cooperation and assistance. Members of the committee were: Harry K. Hines, Cincinnati, chairman; George J. Schroer, Sidney; George H. McIllroy, Celina; Frank F. A. Rawling, Toledo; Harry A. Haller, Cleveland; Carl C. Nohe, Akron; B. C. Diefenbach, Martins Ferry; James A. L. Toland, Cambridge; W. M. Singleton, West Portsmouth; Robert E. Swank, Chillicothe; N. J. M. Klotz, Wadsworth.

New Officers Installed

Dr. Martin then asked all of the officers, councilors and A. M. A. delegates and alternates to the rostrum. He installed them into office.

Following this Dr. Martin presented the official gavel of the Association to the incoming President, Dr. George A. Woodhouse. Dr. Woodhouse accepted the gavel and presented Dr. Martin with the official gold past-president's button.

Dr. Woodhouse then addressed the House of Delegates briefly, outlining some of the major questions which would have to be considered during the coming year. He requested the cooperation and assistance of the House of Delegates as well as all of the officers, councilors and committeemen of the State Association and the officers and committeemen of the county medical societies.

Committee Appointments

The following standing committee appointments were made by Dr. Woodhouse and officially confirmed by the House of Delegates:

Committee on Education—Dr. Charles S. Higley, Shaker Heights, reappointed for a term of five years. Dr. Thomas Rardin, Columbus, appointed a member of the committee for the years 1958-1959, 1959-1960, 1960-1961, filling the unexpired term of Dr. John A. Prior, Columbus, and to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. Frank F. A. Rawling, Toledo, reappointed for a term of five years. Dr. Daniel E. Earley, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Committee on Public Relations and Economics—Dr. John H. Budd, Cleveland, reappointed for a term of five years. Dr. Frederick P. Osgood, Toledo, a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—Dr. Benjamin Felson, Cincinnati, for a term of one year; Dr. Miner W. Seymour, Columbus, for a term of two years; Dr. Ralph K. Ramsayer, Canton, for a term of three years; Dr. Jay Jacoby, Columbus, and Dr. F. A. Simeone, Cleveland, each for a term of four years; Dr. Edwin Ellison, Columbus and Dr. I. Miller, Urbana, each for a term of five years. (Hold-over committee members are: Dr. A. Carlton Ernstene, Cleveland, who was designated chairman for the ensuing year; Dr. Maurice Schnitker, Toledo; and Dr. Maurice M. Kane, Greenville.)

New Business

Under the item of new business Dr. Charles Pavey, Columbus, presented the following motion which was **approved by official action:** That the Council be instructed to make available a minimum of six to eight pages in *The Ohio State Medical Journal* in each of three issues immediately prior to the poll on Social Security for presentation of arguments pro and con on this question.

Dr. Woodhouse stated that he desired to express his appreciation to the members of the Columbus office staff for their efficient work in planning for and carrying on the activities of the Annual Meeting. **His expression of appreciation was loudly applauded by the House of Delegates.**

Dr. George W. Petznick, Cleveland, then asked for recognition. He presented a motion expressing appreciation on behalf of the Ohio State Medical Association to all who had had any part in the annual meeting or preparing for it; to the physicians of Cincinnati and their wives for their courtesies; and to the press, radio, TV and hotels of Cincinnati for the part which they played in making this year's meeting so successful. **This motion was adopted unanimously by the House of Delegates.**

The House of Delegates was advised that the 1959 Annual Meeting would be held in Columbus the week of April 19 and the 1960 Annual Meeting would be held in Cleveland the week of May 15, such places and times having been selected by The Council.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary

HOUSE OF DELEGATES
ROLL CALL—1958 MEETING

County	Delegate	First Session	Second Session
	FIRST DISTRICT		
ADAMS	Richard L. Woodyard	Present	
BROWN			
BUTLER	John A. Carter	Present	Present
	Neil Millikin	Present	Present
CLERMONT	Carl A. Minning	Present	Present
CLINTON	Edmond K. Yantes	Present	Present
HAMILTON	H. C. Beekley	Present	
	Harry K. Hines	Present	Present
	Richard B. Homan	Present	Present
	R. E. Howard	Present	
	Charles W. Hoyt	Present	Present
	J. Robert Hudson		Present
	Daniel V. Jones	Present	Present
	J. Harold Kotte	Present	Present
	Robert D. Mansfield	Present	
	James D. Phinney	Present	Present
	Virgil A. Plessinger	Present	
	Thomas J. Radley	Present	Present
	Stuart A. Schloss		Present
	Robert M. Sherman	Present	Present
	H. C. Shirkey		Present
	Clayton R. Sikes, Jr.		Present
HIGHLAND	J. Martin Byers	Present	Present
WARREN	O. L. Layman	Present	Present
	SECOND DISTRICT		
CHAMPAIGN	Isador Miller	Present	Present
CLARK	John M. Summers	Present	Present
	Ray M. Turner	Present	Present
DARKE	Maurice M. Kane	Present	Present
GREENE	Paul D. Espey	Present	Present
MIAMI	Dale A. Hudson	Present	Present
MONTGOMERY	Kenneth D. Arn	Present	Present
	Lynne E. Baker	Present	Present
	John R. Brown	Present	
	H. R. Cammerer	Present	Present
	Theodore L. Light	Present	
	G. L. Parkin		Present
	M. D. Prugh		Present
PREBLE	C. J. Brian	Present	
SHELBY	George J. Schroer	Present	Present
	THIRD DISTRICT		
ALLEN	Fred P. Berlin	Present	Present
AUGLAIZE	Elizabeth Y. Kuffner	Present	Present
CRAWFORD	Carl J. Ide		Present
HANCOCK	Harold K. Treece	Present	Present
HARDIN	Floyd M. Elliott	Present	Present
LOGAN	H. L. Mikesell		Present
MARION	John T. Boxwell		Present
	Thomas N. Quilter	Present	
MERCER	George H. McIllroy	Present	Present
SENECA	Walter A. Daniel	Present	
VAN WERT	Edwin Wm. Burnes	Present	Present
WYANDOT	T. R. Huston	Present	
	Allen F. Murphy		Present
	FOURTH DISTRICT		
DEFIANCE	William S. Busteed	Present	Present
FULTON	Benjamin Reed	Present	Present
HENRY	Thomas F. Tabler	Present	Present
LUCAS	Henry D. Cook	Present	
	Edmond F. Glow		Present
	J. Lester Kobacker	Present	Present
	A. J. Kuehn	Present	Present
	Edward F. Ockuly	Present	Present
	Frank F. A. Rawling	Present	Present
	Howard E. Smith	Present	Present
OTTAWA	George A. Boon	Present	Present
PAULDING	D. E. Farling	Present	Present
PUTNAM	Milo B. Rice		Present
SANDUSKY			
WILLIAMS	John R. Riesen	Present	Present
WOOD	Roger Peatee	Present	Present
	FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	Present	Present
CUYAHOGA	James O. Barr	Present	Present
	Joseph L. Bilton	Present	Present
	G. H. Brown	Present	Present
	F. L. Browning	Present	Present
	John H. Budd	Present	Present
	C. A. Colombi	Present	Present
	Eduard Eichner		Present
	Eugene A. Ferreri	Present	Present
	John J. Grady	Present	Present
	Harry A. Haller	Present	
	J. B. Hazard	Present	Present
	H. D. Iler	Present	Present
	C. R. Jablonoski	Present	
	Fred R. Kelly	Present	Present
	John A. Kenney, Jr.	Present	Present
	Thomas D. Kinney		Present
	Paul A. Mielcarek	Present	Present
	Philip J. Robecheck	Present	Present
	Paul J. Schildt	Present	Present
	A. B. Schneider	Present	Present
	Leo H. Simoson	Present	Present
	Edwin L. Smith	Present	Present
GEAUGA			
LAKE	Benjamin S. Park	Present	Present
	SIXTH DISTRICT		
COLUMBIANA	John A. Fraser	Present	Present
MAHONING	Paul J. Mahar	Present	Present
	H. P. McGregor	Present	Present
	Asher Randell	Present	Present
	Craig C. Wales		Present
PORTAGE	Myron W. Thomas	Present	Present
STARK	Mark G. Herbst	Present	Present
	John R. Seesholtz	Present	Present
	J. B. Walker	Present	Present
	William A. White, Jr.	Present	Present
SUMMIT	Joseph J. Eckert	Present	Present
	Harold E. Muller	Present	Present
	H. O. Musser	Present	Present
	C. C. Nohe	Present	Present
	Donald M. Traul		Present
TRUMBULL	E. G. Caskey	Present	Present
	Raymond Ralston	Present	Present
	SEVENTH DISTRICT		
BELMONT	B. C. Diefenbach	Present	Present
CARROLL	Glenn C. Dowell	Present	Present
COSHOCTON	W. R. Agricola	Present	Present
HARRISON			
JEFFERSON	S. L. Burkhardt		Present
MONROE			
TUSCARAWAS	Joseph W. Hamilton	Present	Present
	EIGHTH DISTRICT		
ATHENS	Eleanora Schmidt	Present	Present
FAIRFIELD	J. L. Kraker	Present	Present
GUERNSEY	James A. L. Toland	Present	Present
LICKING	Raymond G. Plummer	Present	Present
MORGAN	Henry Backman		Present
MUSKINGUM	J. Herbert Bain		Present
	A. C. Ormond	Present	
NOBLE			
PERRY	Charles E. Bope		Present
WASHINGTON	Kenneth E. Bennett	Present	Present
	NINTH DISTRICT		
GALLIA	Keith R. Brandeberry	Present	Present
HOCKING			
JACKSON	C. C. Fitzpatrick	Present	Present
LAWRENCE	George N. Spears	Present	Present
MEIGS	Roger P. Daniels	Present	Present
PIKE	George W. Cooper	Present	Present
SCIOTO	W. M. Singleton	Present	Present
VINTON	H. D. Chamberlain	Present	Present
	TENTH DISTRICT		
DELAWARE	D. L. Smith		Present
FAYETTE	Thomis J. Hancock	Present	Present
FRANKLIN	Drew J. Arnold	Present	
	Perry R. Ayres		Present
	William F. Bradley	Present	Present
	James C. Good	Present	Present
	Philip B. Hardymon	Present	Present
	Edward W. Harris	Present	Present
	Reuben B. Hoover	Present	Present
	Robert M. Inglis	Present	
	Charles W. Pavey		Present
	Judson D. Wilson	Present	
KNOX	Henry T. Lapp	Present	Present
MADISON	Sol Maggied	Present	Present
MORROW	Joseph P. Ingmire	Present	
	Francis W. Kubbs		Present
PICKAWAY	Frank R. Moore	Present	Present
ROSS	Robert E. Swank	Present	Present
UNION	E. J. Marsh	Present	Present
	ELEVENTH DISTRICT		
ASHLAND	M. D. Shilling	Present	Present
ERIE	E. J. Meckstroth	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	O. J. Nicholson	Present	Present
LORAIN	James T. Stephens	Present	Present
	George R. Wiseman	Present	Present
MEDINA	N. J. M. Klotz	Present	Present
RICHLAND	P. O. Staker	Present	Present
	Harry Wain	Present	Present
WAYNE	Albert B. Huff	Present	Present

(Continued on Next Page)

New Councilors Greeted by Colleagues



Members of The Council came forward following the election to greet two new members: Left to right, standing: Dr. Pease, Dr. Monger, Past-President Charles L. Hudson, Dr. Petznick, President Martin, Incoming President Woodhouse; the newly elected First District Councilor, Dr. Charles W. Hoyt, and new Third District Councilor, Dr. Floyd M. Elliott; Dr. Hopkins and Dr. Dooley.

(House Roll Call—Continued)

	Delegate	First Session	Second Session
	OFFICERS		
President	Robert S. Martin	Present	Present
President-Elect	G. A. Woodhouse	Present	Present
Past-President	Richard L. Meiling	Present	Present
Treasurer	Geo. J. Hamwi	Present	Present
	COUNCILORS		
District			
First	Frank H. Mayfield	Present	Present
Second	R. Dean Dooley	Present	Present
Third	James R. Jarvis	Present	Present
Fourth	Paul F. Orr	Present	Present
Fifth	George W. Petznick	Present	Present
Sixth	C. A. Gustafson	Present	Present
Seventh	Robert E. Hopkins	Present	Present
Eighth	William D. Monger	Present	Present
Ninth	C. L. Pitcher	Present	Present
Tenth	Edwin H. Artman	Present	Present
Eleventh	H. T. Pease	Present	Present
	Totals	**148**	**153**

American Medical Golfing Association Tournament Scheduled June 22

The American Medical Golfing Association is holding its annual golf tournament on Sunday, June 22, in conjunction with the AMA Annual Session which begins on Monday, June 23. The course is the beautiful Olympic Lakeside Golf and Country Club, San Francisco, Calif. This will be a day of rest and relaxation with golf, luncheon, banquet and prizes.

Tee off time is 8 a. m. to 2 p. m. All doctor golfers are invited to attend. Handicaps, scratch to 30, in flights. Additional information may be obtained from James J. Leary, M. D., Secretary, 450 Sutter Street, San Francisco, Calif.

Identification Card for Patients On Anticoagulant Therapy

An "emergency" identification card for the protection of patients on long-term anticoagulant therapy is now available to physicians from the Ohio State Heart Association and its chapters.

The card, designed as a wallet insert, was developed as a result of requests from physicians seeking to protect their patients on anticoagulants in case of accident, dental surgery or other treatment that may induce bleeding. It points out that the bearer "is being treated with anticoagulants which slow down clotting of the blood." In case of emergency—bleeding, injury or illness—the card advises that a doctor be called, since the patient may require an antidote.

The card contains space for the name, address and phone number of the individual's physician. There is also space to indicate the kind of anticoagulant prescribed and the patient's blood type. The card was designed with the approval of the Committee on Prothrombin Determinations of the American Heart Association.

In addition to making the anticoagulant identification card available to physicians, the Heart Association also is calling it to the attention of dentists, hospital emergency room personnel, nurses, police and others who most commonly handle emergencies.

Physicians may obtain samples of the identification card from their local Heart Association or from the Ohio State Heart Association at 131 East State Street, Columbus 15, Ohio.

Annual Meeting in Review . . .

Here Are Some Highlights and Sidelights on Happenings at the Cincinnati Meeting, Among Them Several Awards Presented for Outstanding Exhibits

OFFICIAL proceedings of the House of Delegates and other reports of the 1958 Annual Meeting in Cincinnati are printed elsewhere in this issue under their respective headings. The reader is referred to the index on the inside front cover for page numbers. To more graphically portray what took place at the meeting, *The Journal* has reproduced a number of photographs taken there. Following is additional information in which members will be interested:

Guest Speakers

Approximately a hundred physicians took part in the Scientific Program at the Annual Meeting, in addition to the many who were on committees or otherwise participated in the plans for a successful meeting.

Among those who spoke were several out-of-state guests including the following: Dr. Edith L. Potter, Chicago, professor of pathology, Department of Obstetrics and Gynecology, University of Chicago; Dr. William W. Scott, professor of urology, Johns Hopkins University; Dr. Stanley R. Friesen, Kansas City, Kans., associate professor of surgery and oncology, University of Kansas; Dr. Hans Popper, New York, professor of pathology, Columbia University; Dr. Edward H. Lambert, Rochester, Minn., associate professor of physiology, Mayo Foundation, Graduate School of the University of Minnesota; Dr. F. J. L. Blasingame, Chicago, executive vice-president of the AMA; Dr. Irving H. Leopold, Philadelphia, professor and head of the Department of Ophthalmology, Graduate School of Medicine, University of Pennsylvania; Dr. David B. Allman, Atlantic City, President of the AMA. Guest lay speaker was Mr. Joseph F. McElligott, New York City, business and tax consultant.

Incoming President Honored

The folks in Pleasant Hill gave a warm reception to Dr. Woodhouse on his return from the Annual Meeting after being installed as President. The occasion was a tea for Dr. and Mrs. Woodhouse on Sunday afternoon, April 20. Approximately 150 friends and associates gathered at the Pleasant Hill Congregational Christian Church, with the members of Women's Fellowship of the church as hostesses.

Scientific Exhibit

The Scientific Exhibit was an important feature of the Annual Meeting and drew a steady stream of members and visitors to the South Hall of the Netherland Hilton. There was a total of 46 individual displays in the exhibit.

A special committee evaluated the exhibits and on the basis of their findings presented nine awards. The awards were as follows:

Gold Award in Education Field to the exhibit "Premature Care," sponsored by Drs. Edward A. Wagner, Daniel V. Jones, Carl A. Koch, University of Cincinnati College of Medicine, Department of Pediatrics and the Premature Service, Cincinnati General Hospital.

Gold Award in the Research Field to the exhibit "Cardiac Output," sponsored by Dr. Robert E. Zipf, director of the Department of Research, Miami Valley Hospital, Dayton.

Silver Award in the Education Field to the exhibit "Surgical Correction of Acquired Heart Disease—Open vs. Closed Techniques," sponsored by Dr. Earle B. Kay, D. Mendelsohn, Thomas MacKrell and H. A. Zimmerman, St. Vincent Charity Hospital, Cleveland.

Silver Award in the Research Field to the exhibit "Congenital Heart Lesions: Diagnosis and Surgical Correction," sponsored by Drs. F. S. Cross, H. F. Inderlied, F. A. Oldenburg, St. Luke's Hospital, Cleveland.

Bronze Award in the Education Field to the exhibit, "Changing Pattern of Leukemia," sponsored by Drs. C. S. Higley, W. C. Stoner, Jr., D. A. Baumgartner and Jack Berman, St. Luke's Hospital, Cleveland.

Bronze Award in Research Field to the exhibit "Vertebral Angiograms of the Brain," sponsored by Dr. H. F. Plaut, Radiology Service, Veterans Administration Center, Dayton, and Ohio State University, Columbus.

Special Award to the exhibit "Accident Prevention and Poison Control," sponsored by Paul A. Hayden, assistant administrator, Akron Children's Hospital; Dr. John Norman, Akron, State

Councilors and Guests Enjoy the Banquet



These photos taken at the Banquet show some of the Councilors and distinguished guests in the picturesque Pavillon of the Netherland-Hilton Hotel.

chairman, Accident Prevention Committee, American Academy of Pediatrics.

Special Award to the exhibit "Family Doctor's Bag," a comparison of the old and the new, sponsored by the Southwestern Ohio Society of General Physicians.

Dr. Mendelsohn Honored

An event during the Annual Banquet was the presentation of the Daniel Drake Award, sponsored by the Southwestern Ohio Society of General Physicians, a local component of the Ohio Academy of General Practice. The award was presented to Dr. Harry R. Mendelsohn, Madisonville, a charter member of the organization and its first president. Dr. Mendelsohn has contributed much time and effort in behalf of the Cincinnati Academy, local hospitals, civil defense and disaster services.

Presentation was made by Dr. A. H. Willke, Cincinnati, president of the SOSGP.

The Meeting Made News

The meeting received coverage from the Associated Press, United Press and International News Service. Representing the *Cincinnati Enquirer* were James Golden, medical reporter; George Amick and Bill Collins. Helen Detzel covered the sessions for the *Cincinnati Times Star* and Sharon Maloney for the *Cincinnati Post.*

AMA President David B. Allman was interviewed for a half-hour on April 16 by Ruth Lyons on WLW radio and television, which included a network of four TV and three radio stations, servicing cities as far away as Columbus, Dayton and Indianapolis. Peter Grant, WLW newscaster also participated in the interview.

At a press conference held on the same date, Bill Aughenbaugh, of the WLW television staff, recorded a sound motion picture statement by Dr. Allman, and representatives of Radio Stations WSAI and WKRC secured transcribed interviews from the AMA President.

All daily and weekly newspapers in Ohio were supplied with advance stories of the meeting, with names of local members expected to participate. In addition, these same papers received a roundup story on the resolutions enacted at the House of Delegates and the officers elected to serve the Association for the ensuing year.

The OSMA public relations staff supplied the wire services and the Cincinnati newspapers and radio and television directors with the news of the meeting by messenger during the course of activities.

The 13th International Congress on Occupational Health will be held in New York City during July, 1960.



New OSMA President-Elect Frank H. Mayfield is shown addressing the second session of the House of Delegates.



Guest of the Association was Dr. F. J. L. Blasingame, new General Manager of the AMA, who spoke on the subject, "It's Your AMA."

Annual Meeting Attendance . . .

More than 1500 Physicians and Medical Students Attend 1958 Sessions In Cincinnati, Representing the Association's Members from 85 Counties

THE total attendance at the 1958 OSMA Annual Meeting in Cincinnati April 15-17 was 2535, of which 1491 were physicians and 45 medical students. The actual break-down of those present was as follows: Members of the Association, 1327; guest physicians, including residents, interns and other physician guests, 164; medical students, 45; members of the Woman's Auxiliary and miscellaneous guests, 674; Scientific and Technical Exhibitors, 325; total, 2535.

Following are registration figures for members by counties, a comparison of attendance figures at Annual Meetings from 1919 through 1958, followed by a roster of members who registered for the 1958 meeting:

Registration, 1958 Annual Meeting by Counties and Membership Data

County	Total Membership Dec. 31,'57	Total Membership Apr. 10,'58	Annual Meeting Registration
Adams	12	11	5
Allen	114	109	10
Ashland	24	24	1
Ashtabula	59	51	1
Athens	35	29	6
Auglaize	18	15	6
Belmont	54	55	3
Brown	13	13	5
Butler	158	154	37
Carroll	11	11	3
Champaign	17	13	9
Clark	117	109	25
Clermont	24	25	9
Clinton	25	25	12
Columbiana	77	62	5
Coshocton	22	21	4
Crawford	35	29	1
Cuyahoga	2090	1958	97
Darke	24	27	9
Defiance	18	18	1
Delaware	25	25	4
Erie	59	62	9
Fairfield	50	49	11
Fayette	17	16	4
Franklin	813	787	152
Fulton	23	24	2
Gallia	34	34	5
Geauga	12	10	0
Greene	42	40	11
Guernsey	36	31	3
Hamilton	1167	1123	430
Hancock	41	40	5
Hardin	26	22	3
Harrison	10	10	1
Henry	13	14	2
Highland	22	20	9
Hocking	11	12	2
Holmes	9	9	2
Huron	23	25	3
Jackson	16	14	2
Jefferson	58	54	4
Knox	32	31	6
Lake	64	63	2
Lawrence	27	27	5
Licking	62	52	10
Logan	25	24	7
Lorain	159	143	9
Lucas	559	529	33
Madison	12	13	1
Mahoning	295	309	18
Marion	67	55	6
Medina	40	39	5
Meigs	9	9	1
Mercer	19	21	4
Miami	58	54	19
Monroe	3	2	—
Montgomery	485	468	92
Morgan	5	5	1
Morrow	8	9	3
Muskingum	64	65	8
Noble	3	3	—
Ottawa	20	19	2
Paulding	10	8	1
Perry	12	12	2
Pickaway	17	16	3
Pike	9	10	3
Portage	46	42	4
Preble	11	10	3
Putnam	14	12	1
Richland	111	107	18
Ross	49	46	16
Sandusky	43	43	5
Scioto	76	74	18
Seneca	41	41	4
Shelby	17	17	1
Stark	315	310	19
Summit	441	440	25
Trumbull	120	119	6
Tuscarawas	58	58	15
Union	20	17	9
Van Wert	16	16	2
Vinton	2	2	1
Warren	17	14	4
Washington	29	28	5
Wayne	58	39	5
Williams	17	17	2
Wood	36	35	3
Wyandot	14	13	3
Totals	8030	8666	1327

ANNUAL MEETING REGISTRATION FOR 1919-1958 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with A. M. A.						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	184	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535



These are Past-Presidents of the Association who attended The Council dinner on Tuesday evening. Seated, left to right: Drs. Paul A. Davis, H. M. Platter, E. O. Swartz, Carl A. Lincke, Edward J. McCormick (also Past-President of the AMA) and H. M. Clodfelter. Standing, l. to r.: Drs. Merrill D. Prugh, Richard L. Meiling, C. C. Sherburne, Outgoing President Robert S. Martin, Charles L. Hudson and L. Howard Schriver.

MEMBERS OF THE STATE ASSOCIATION REGISTERED AT 1958 MEETING

Adams County—Samuel C. Clark, Kenneth C. Jee, Alexander Salamon, Hazel L. Sproull, Richard Lee Woodyard.

Allen County—James C. Belt, Fred P. Berlin, Patrick A. Connaughton, Raymond B. Croissant, John D. Hubbell, Charles H. Leech, Melvin A. Mulvania, Walter A. Noble, William E. Noble, Roger L. Tecklenberg.

Ashland County—Myrle D. Shilling.

Ashtabula County—Shepard A. Burroughs.

Athens County—Wolfard Baumgartel, Hubert H. Fockler, Roary A. Murchison, Tamin J. Najm, Eleanora Schmidt, Stephen E. Simay.

Auglaize County—William V. Barton, Elizabeth Y. Kuffner, Robert S. Oyer, James R. Romaker, Richard H. Schaefers, T. H. Will.

Belmont County—David Danenberg, B. C. Diefenbach, Murray B. Hunter.

Brown County—Lyle C. Franz, Vytautas Karoblis, Charles H. Maly, Wilbur S. Powell, Ralph F. Wilkins.

Butler County—James M. Anderson, H. Thomas Atkins, Hugh J. Baker, John A. Carter, Rodney C. Caudill, Felix Gustav Cohn, Ernest B. Cunningham, William A. Davin, Louis B. Gaker, Mabel E. Gardner, Lawrence J. Gibboney, Arnold Gross, Jack L. Harris, William H. Henry, Vera Coombs Iber, Paul N. Ivins, Robert P. Johnson, Edward Kezur, Kurt E. Lande, Ralph H. Leyrer, Henry A. Long, Michael A. Matthews, Silvia P. Matthews, Richard H. Mense, Neil Millikin, William U. Neel, William Polanka, Erich W. Ringel, Bernard H. Roberts, Carl A. Roden, Paul E. Smalley, Kenneth M. Smith, Mildred Law Snyder, Clyde I. Stafford, Gene M. Thompson, Robert M. Wilson, Abraham Wolkin.

Carroll County—Glenn C. Dowell, Robert C. Lanzer, Carl A. Lincke.

Champaign County—Harold Carter, Victor R. Frederick, Forrest E. Lowry, I. Miller, John K. Pond, William R. Pudvan, Arthur B. Ream, Theodore E. Richards, Myron J. Towle.

Clark County—Frank W. Anzinger, Jr., Edwin E. Ash, Robert B. Beam, Bernard J. Begley, William H. Crays, John A. Davidson, Samuel K. Gerson, Guenter E. Heinrich, Dorothy C. Heinz, George R. Horton, Clarence W. Hullinger, Wesley E. Knaup, John D. Lefevre, Robert A. McLemore, Morris B. Martin, William H. Miller, George F. Parker, Nicholas B. Pavlatos, Lillian M. Posch, William W. Roby, Elliott W. Schilke, J. H. Shanklin, John M. Summers, Ray M. Turner, S. C. Yinger.

Clermont County—Cecil F. Barber, Harry M. Breuer, John M. Coleman, Walter H. Culley, Carl

A. Minning, Allan B. Rapp, Charles M. Simmons, Frederick S. Skeen, George J. Watkins.

Clinton County—F. J. Boyd, Jr., Mary R. Boyd, Richard R. Buchanan, Robert Conard, Robert M. Cronebaugh, J. H. Frame, Roy D. Goodwin, Kelley Hale, Frank G. Plymire, Ralph H. Vance, John K. Williams, Edmond K. Yantes.

Columbiana County—Roy C. Costello, John A. Fraser, Virgil C. Hart, Raymond T. Holzbach, Robert N. Osmundsen.

Coshocton County — Waldemar R. Agricola, Robert E. Hopkins, H. H. Schwindt, Norman L. Wright.

Crawford County—C. J. Ide.

Cuyahoga County — Kenneth C. Archibald, George Austen, Jr., James O. Barr, John D. Battle, Jr., D. A. Baumgartner, Jack H. Berman, Joseph L. Bilton, Charles H. Brown, George Henry Brown, George H. Brown, Francis L. Browning, Peter A. Bruch, John H. Budd, Kenneth H. Burdick, Hilda B. Case, William F. Collins, Jr., Christopher A. Colombi, Nadene Coyne, Irving I. Cramer, E. H. Crawfis, Russell B. Crawford, Thomas I. Crawford, Frederick S. Cross, Nicholas G. DePiero, Carroll C. Dundon,

Eduard Eichner, A. Carlton Ernstene, Eugene A. Ferreri, James P. Frackelton, Ralph J. Frackleton, William J. Gardner, Donald M. Glover, John J. Grady, Alvin P. M. Hall, Harry A. Haller, Harold E. Harris, John W. Harrison, Robert B. Hauver, William A. Hawk, John B. Hazard, Sidney W. Helperin, Charles S. Higley, Stanley O. Hoerr, Howard H. Hopwood, Jr., Charles L. Hudson, Alfred W. Humphries, Harris D. Iler, H. F. Inderlied,

Chester R. Jablonoski, Albert L. Jones, Walter R. Katzenmeyer, Earle B. Kay, Fred R. Kelly, James I. Kendrick, Roscoe J. Kennedy, John A. Kenney, Jr., Thomas D. Kinney, Peter J. Kmieck, Vincent T. LaMaida, Charles L. Leedham, Fay A. LeFevre, Charles Long, II, Melvin A. Lucas, Harvey J. Mendelsohn, Robert Dean Mercer, Paul A. Mielcarek, Clarence J. Morell, Paul A. Nelson, William A. Nosik, Joseph Nurenberg, Frederick A. Oldenburg,

Irvine H. Page, George W. Petznick, Frank J. Rack, P. J. Robechek, Vernon C. Rowland, Sr., Edward C. Roy, Herbert W. Salter, Arthur L. Scherbel, Paul J. Schildt, A. Benedict Schneider, James F. Seliskar, Mildred H. Shelly, F. A. Simeone, Leo H. Simoson, Edwin L. Smith, Erma A. Smith, Donald A. Snyder, Willard C. Stoner, Jr., William C. Strittmatter, Harold R. Swan, Paul J. Vignos, Jr., Elden C. Weckesser, Herman C. Weinberg, Guy H. Williams, Jr., Benjamin J. Wolpaw, Burdett Wylie.

Darke County—V. Ray Boli, E. Westbrook Browne, Maurice M. Kane, Paul G. Lenhert, John S. Meyers, Peter H. Mulder, Gilbert E. Sayle, Alvan E. Thuma, Robert V. Wade.

Defiance County—William S. Busteed.

Delaware County — Adelbert R. Collander, George J. Parker, Douglas L. Smith, William L. Vogt.

Erie County—William F. Burger, James R. Hart, Ross M. Knoble, Paul S. LaFollette, C. F. Lavender, David R. Lehrer, Emil J. Meckstroth, Gordon F. Ogram, Sigismund Vechey.

Fairfield County—Adam David Echert, Stephen R. Hodsden, William S. Jasper, A. M. Kelley, Victor N. Kistler, Jack L. Kraker, William D. Monger, Carl R. Reed, Harold J. Schwendeman, Lewis H. Urling, Jr., Robert E. Whetsone.

Fayette County—Philip E. Binzel, Jr., Thomas J. Hancock, Jack H. Persinger, Byers W. Shaw.

Franklin County—Benjamin W. Abramson, J. Garfield Alcorn, Homer A. Anderson, Shirley Armstrong, Drew J. Arnold, Perry R. Ayres, Frederick S. Barends, Earl H. Baxter, Harry C. A. Beach, Floyd M. Beman, Henry Bergman, Ross M. Blesch, William R. Blesch, George H. Bonnell, Jr., Jack R. Bontley, Richard W. Booth, William F. Bradley, Margaret W. Bridwell, William H. Brunie, Maurice G. Buckles, Olan P. Burt,

Clarence E. Carnahan, Lewis W. Cellio, Leon G. Claassen, H. William Clatworthy, Jr., George D. Clouse, George W. Cooperrider, James M. Coulter, Dana W. Cox, John P. Crawford, Thomas R. Curran, H. B. Davidson, Walter DeLaMotte, Dale R. Dickens, Paul R. Dillahunt, Charles A. Doan, Robert J. Duran, Nathan P. Eisenberg, Harry E. Ezell, Jonathan Forman, Huston F. Fulton, Clarence M. Gallagher, John P. Garvin, Joseph M. Gettrost, Howard D. Giles, James C. Good, Helen P. Graves,

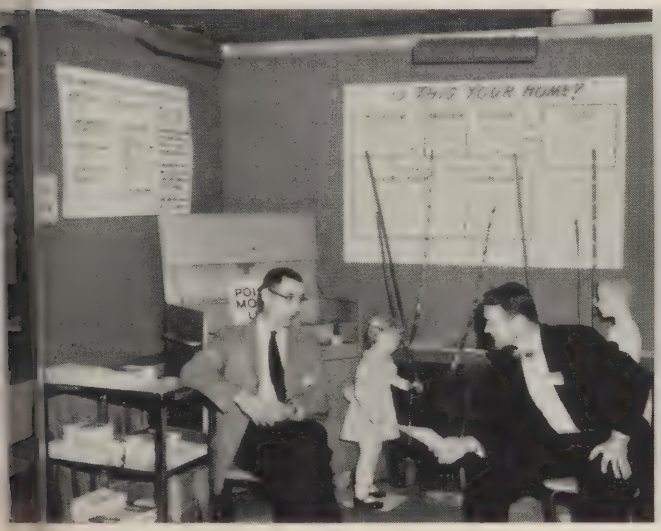
William L. Hall, William Hamelberg, George J. Hamwi, James A. Hardie, Charles W. Harding, George T. Harding, George T. Harding, Jr., P. B. Hardymon, Edward W. Harris, Harold K. Harris, Margot D. Hartmann, William H. Havener, Robert A. Heilman, Eldred B. Heisel, James L. Henry, Willis H. Hodges, Jr., George R. Hoeflinger, Zeph J. R. Hollenbeck, Reuben B. Hoover, Don M. Hosier, Oliver W. Hosterman, Hugh B. Hull, Jr., H. I. Humphrey, William E. Hunt, Robert M. Inglis, Robert J. Izant, Arthur G. James, Ralph J. Johansmann, Ernest W. Johnson, John R. Jones,

Max P. Kanter, Paul Kirch, Gilman D. Kirk, Robert C. Kirk, Reynold E. Klages, Jr., George O. Kress, Robert H. Kuhn, Frank L. Lally, Edward C. Lawless, Richard J. Lescoe, David R. Lewis,





Left: Bronze Award winning exhibit in the field of research, "Vertebral Angiograms of the Brain." **Right:** Gold Award winning exhibit in the research field, "Cardiac Output."





Left: Special Award winning exhibit was this display on "Accident Prevention and Poison Control." **Right:** Another Special Award winner was this exhibit entitled, "Family Doctor's Bag."





Left: Silver Award winning exhibit, in the education field, "Surgical Correction of Acquired Heart Disease—Open vs. Closed Techniques." **Right:** Bronze Award winning exhibit in the field of education, "Changing Pattern of Leukemia."

Tom F. Lewis, Richard L. McFarland, Torrence A. Makley, Lillian Marks, Robert L. Marshall, George T. Mathews, Charles W. Matthews, Charles V. Meckstroth, Richard L. Meiling, Nicholas Michael, Jack W. Miles, George F. Millay, Paul R. Miller, Jacob Moses, Charles S. Myers, Jr., Harry O. Newland, Munroe W. Palestrant, Milton M. Parker, Ralph M. Patterson, Carey B. Paul, Jr., Charles W. Pavey, Vol K. Philips, Herbert M. Platter, Allen D. Puppel, Robert L. Reinhart, Mary C. Richards, John P. Riepenhoff, William O. Robertson, Jr., Leabelle I. Ross, Norman O. Rothermich, Nellija O. Rubenis, Anthony Ruppersberg, Jr.,

William H. Saunders, Mark L. Saylor, Roy J. Secrest, Miner W. Seymour, Joseph H. Shepard, Clifford C. Sherburne, Howard D. Sirak, John P. Smith, David J. Spangler, Pearl C. Staker, Robert B. Stevenson, Walter M. Stout, Mabel Richards Tarbell, Jack N. Taylor, William N. Taylor, C. B. Theodotou, E. V. Turner, Lawrence E. Turton, John P. Urban, Richard E. Vance, Emmerich Von Haam, Thomas P. Wangler, John A. Whieldon, James H. Williams, Roger D. Williams, Judson D. Wilson, William W. Wiltberger, Bruce K. Wiseman, Kurt Witton, Ralph E. Worden, Richard W. Zollinger, Maurice L. Zox.

Fulton County—Clarence F. Murbach, Ben H. Reed, Jr.

Gallia County—Keith R. Brandeberry, Oscar W. Clarke, Marcus J. Magnussen, John C. Markley, Thomas W. Morgan.

Greene County—Ray W. Barry, Paul D. Espey, Robert D. Hendrickson, C. G. McPherson, Meinhard Robinow, J. Robert Schauer, Lester W. Sontag, Harry C. Stoneburner, Harold R. Tharp, John D. Tharp, R. David Warner.

Guernsey County—Merritt C. McCuskey, Robert A. Ringer, James A. L. Toland.

Hamilton County—Nathan R. Abrams, Goffredo S. Accetta, F. Jay Ach, William C. Ahlering, Irwin C. Albert, Edward Alberts, John E. Allen, Nicholas G. Amato, Charles B. Armstrong, Albert I. Aronoff, Nathan Aronoff, Arthur O. Bachman, Robert A. Bader, Taylor W. Barker, Ferris E. Beekley, Henry Clay Beekley, Edward J. Bender, Julien E. Benjamin, Howard Benus, Jerome R. Berman, I. Leonard Bernstein, Joseph B. Biederman, J. Park Biehl, Erwin C. Binstadt, Paula Biren, Donald J. Birmingham, Nancy Blades, Sanford Blank, Hermann Blatt, Norman H. Blatt, Stanley L. Block, C. D. Bobowski, Byron E. Boyer, Robert Brandt, John R. Braunstein, Gertrude D. Brecht, Donald E. Brinkmann, Frederick Brockmeier, George E. Brown, Michael T. Brown, Samuel A. Brown, Clinton H. Buford, Max R. Burger, Leonard A. Burgin, Paul A. Busam,

James S. Caldwell, James W. S. Calvert, John B. S. Campbell, John F. Cardosi, Edmund C. Casey, Joseph M. Casper, Gerald H. Castle, Harold Norbert Cavanaugh, Sherwood A. Chamberlain, Owen C. Clark, James J. Clear, James Francis Cleary, Jr., Frank Clement, Chatham G. Clements, Sander Cohen, Helen S. Compton, Halford F. Conwell, Louis E. Cook, Robert E. Cooke, Edgar M. Corrill, William H. Craddock, John J. Cranley, Joseph G. Crotty, A. Harry Crum, Ralph B. Cunningham, S. Bertha Dauch, Daniel J. Davies, Alvin Davis, William D. DeVaux, Charles A. DeWert, Mark S. Dine, John H. Dornheggen, Harold F. Downing, Alfred J. Elkins, Edward C. Elsey, Walter G. Engel, Gail S. Englender, Alfred W. Erb, Virginia M. Esselborn,

Howard D. Fabing, Edwin C. Faessler, Carroll J. Fairo, John H. Falk, Emmett Fayen, Benjamin Felson, Charles K. Ferguson, Frank F. Ferris, Willard B. Fessenden, Archie Fine, William M. Fischbach, Herbert C. Flessa, Paul E. Foldes, Starr Ford, J. Philip Fox, Donald J. Frank, Herman A. Freckman, Kenneth A. J. Frederick, Alan S. Freemond, Joseph N. Freiden, Frederick Freihofer, Emil Friedlander, Ben I. Friedman, Eugene P. Fromm, William E. Froschauer, John C. Fuhs,

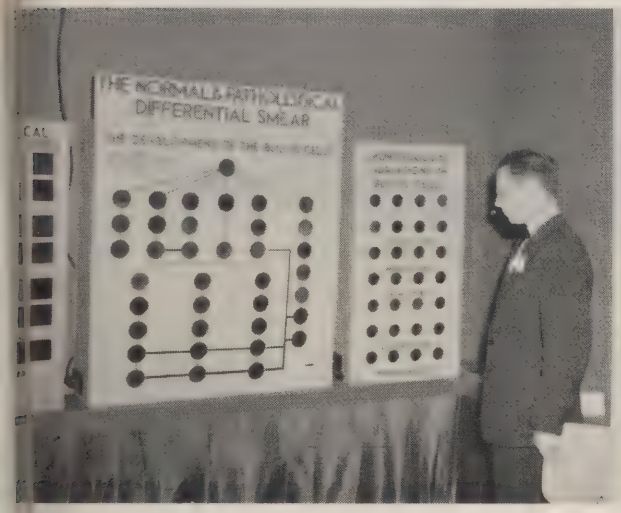
Joseph N. Ganim, Mitchell H. Ganim, Paul G. Geiss, Samuel Gendelman, N. J. Giannestras, Melvin Gillett, James R. Glier, Helen I. Glueck, Lawrence C. Goldberg, Milton M. Goldfarb, Douglas Goldman, Lowell E. Golter, Sander Goodman, Henry M. Goodyear, Ralph S. Grace, Edward A. Grad, Marjorie A. Grad, Paul J. Graham, David L. Graller, Robert S. Green, J. Victor Greenebaum, Paul D. Grove, George M. Guest,

Frederick D. Haffner, John B. Hamblet, Paul V. Hamilton, Gaston B. Hannah, Clarence L. Hans, Jr., Samuel Harris, Edward Hartenian, Rae E. Hartman, O. Warren Hattendorf, Charles E. Hauser, J. Robert Hawkins, J. B. Hayes, Edward Blair Headley, Robert S. Heidt, Joseph D. Heiman, Raymond H. Hellman, Jr., Louis J. Hendricks, Samuel W. Herman, Jack Hertzman, Emily R. Hess, Peter W. Hess, William E. Hillard, Donald W. Hillman, Elliott A. Hilsinger, Harry K. Hines, Leon S. Hirsch, Carl J. Hochhausler, Stephen P. Hogg, Richard B. Homan, Stephen H. Hornstein, Robert E. Howard, Harriet B. Howes, Benjamin Hoyer, Charles W. Hoyt, J. Robert Hudson, John H. Hunt, C. R. Hunter, Hope Hyams,

Arnold Iglauer, L. Courtney Jack, Donald L. Jacobs, Murray S. Jaffe, Joseph H. Jansen, Jerome N. Janson, Thomas S. Jenike, William P. Jennings, William R. Johnson, Jr., Dan V. Jones, Richard A. Jubelirer, Joseph B. Kallenberg, Frederic T. Kapp,



A scene during the early part of the Banquet, just before dancing began in the area reserved for that purpose.





Left: A Special Award went to this exhibit on "Normal and Pathological Blood Smear." **Right:** The Silver Award winning exhibit in the field of research, "Congenital Heart Lesions: Diagnosis and Surgical Correction."

Azad Katchian, Nicholas M. Katona, Elmer G. Katz, Sidney A. Kay, Robert A. Kehoe, Robert A. Kemper, David M. Kerman, Roy L. Kile, Dan J. Kindel, Arthur G. King, Verle R. Kitsmiller, Jules I. Klein, Maurice S. Klein, William W. Klement, Carl A. Koch, Robert P. Koenig, Homer H. Kohler, Herman J. Kooiker, J. Harold Kotte, Robert H. Kotte, Raymond J. Krause, Robert E. Krone, Nathan J. Kursban,

Max C. Labermier, Jr., Joseph A. Lane, Lloyd E. Larrick, Hans W. Lawrence, J. Arthur Leary, Henri LeClaire, Henry D. Lederer, Bruno Leichtentritt, Harry O. Lepsky, Abram A. Levin, Joseph E. Levinson, Janus C. Lindner, Edgar S. Lotspeich, Jr., Gerson Lowenthal, Max L. Lurie, Alfred Lustberg, Donald J. Lyle, Robert A. Lyon,

Bert H. McBride, Harvey G. McCandless, Justin E. McCarthy, George William McClure, John W. McConnell, Lee McHenry, Joseph S. McMath, James R. Mack, Martin B. Macht, Charles Maertz, John J. Maloney, Robert D. Mansfield, John D. Marioni, Maurice D. Marsh, James F. Martin, Kent E. Martin, Lester W. Martin, Mary M. Martin, Esther C. Marting, Robert A. Matuska, Elmer P. R. Maurer, Frank H. Mayfield, John R. Meek, Sidney N. Mendelsohn, Fernando L. Mendez, Jr., George A. Meyers, Harry J. Meyers, S. Gregory Miceli, Donald E. Miller, Eli A. Miller, Henrietta Marie Miller, Joseph J. Miller, James S. Mills, Gordon M. Mindrum, Alexander C. Minella, William A. Moore, Harold Moskovitz, James A. L. Moulton,

Arthur W. Nadler, Frank A. Nantz, A. W. Nelson, Harry G. Nelson, Leo. I. Nelson, Hilmer W. Neumann, Paul V. D. Newland, D. Bruce Nicholson, Jeanne E. Nitchals, Ray O. Nulsen, Carl J. Ochs, Eileen M. O'Ferrell, Dale P. Osborn, Lloyd E. Owens, Lucy O. Oxley, Evalyn M. Partymiller, George F. Patterson, John H. Payne, Warner A. Peck, Jr., Clarke P. Pennington, Harold Pescovitz, Glen W. Pfister, Jr., John J. Phair, Walter B. Phillips, James D. Phinney, Philip E. Piker, Virgil A. Plessinger, Joseph J. Podesta, Alex Pohowsky, Jr., Alice Margaret Posey, Robert H. Preston, Frank Princi, Joseph A. Quigley,

Thomas J. Radley, William Orville Ramey, Con-

Panel Discussion A Feature of the Scientific Program



Typical of the scientific discussion groups was this panel snapped during the Combined Session of Sections on General Practice, Internal Medicine, Radiology and Surgery.

rad O. Ranger, Helena T. Ratterman, Louise W. Rauh, John Edwin Reed, Samuel Reingold, George Renner, Jr., Andrew C. Renz, Charles K. Riddle, William Riddle, C. R. Rittershofer, Samuel Rochwern, Manuel M. Rodarte, Jack F. Rohde, William H. Rohdenburg, Brigitte R. Rosenberg, Louis M. Rosenberg, Philip H. Rosenberg, Ervin S. Ross, William Donald Ross, Robert C. Rothenberg, Carl E. Roush, Eli Rubenstein, Jack H. Rubinstein, Walter B. Rugh, Jr., Henry W. Ryder,

Herschel Sachs, Eugene L. Saenger, Louis A. Safer, Barnet R. Sakler, C. H. Scheetz, Leon Schiff, Carl F. Schilling, Harold S. Schiro, Stuart A. Schloss, Franklin C. Schlueter, Eduardo Z. Schmidt, William C. Schmidter, Jr., Margaret J. Schneider, Benjamin Schneider, L. Howard Schriver, Morris S. Schulzinger, Abe L. Schwartz, Bernard A. Schwartz, Edmund H. Schweitzer, George X. Schwemlein, Ralph C. Scott, Charles A. Sebastian, Frank Seinsheimer, Vincent J. Seiwert, Theodore K. Selkirk,

I. C. Sharon, Denman Shaw, Robert M. Sherman, Harry C. Shirkey, Roland F. Shirley, Clayton R. Sikes, Jr., Nathan Silver, Irvin S. Silverstein, David L. Simon, John E. Singer, Robert E. Slemmer, Hiram H. Slutz, Hugo Dunlap Smith, E. B. Snyder, Frederick A. Snyder, Dora F. Sonnenday, Erich Spiro, Arthur H. Spreen, Leonard J. Stark, Robert A. Stein, C. Roy Steingrube, Edgar C. Steinharter, Francis M. Stephens, Mervin F. Steves, E. V. Stewart, Victor Strauss, Edward S. Strasser, Jr., Cecil Striker, Max Strikman, Warren L. Strohmenger, Garfield L. Suder, Ernest O. Swartz,

William S. Terwilleger, Frederick C. Theiss, Albert E. Thielen, John L. Thinnes, Jr., Clyde S. Thomas, William C. Thornell, Samuel A. Trufant, Harold A. Tuch, Ivan Tuskan, Mark Upson, Jr., Earl C. Van Horn, Ward H. Ventress, F. William Vockell, Frank E. Von Holle,

Carl F. Wagner, Edward A. Wagner, Luben S. Walchef, Millard Wallenstein, Josef Warkany, Calvin F. Warner, Irvin Warth, T. Brent Wayman, Henry E. Wedig, Joseph Weil, Alfred L. Weiner, Josef D. Weintraub, H. B. Weiss, Arthur H. Wells, Daniel A. Whalen, Russell F. Wiggers, Lawrence J. Wilchins, Walter B. Wildman, Harold M. Wiley, Gilbert E. Williams, A. H. Willke, John C. Willke, Ernest R. Wilson, Joseph N. Wilson, Carl A. Wilzbach, Richard L. Witt, Sydney Wolfgang, Edward Woliver, George A. Woodhouse, Jr., Robert M. Woolford, Charles E. Work, Mitchell R. Zavon, Sherwin S. Zeid, Jerome Zeigler, I. Mark Zeligs, Max M. Zinninger.

Hancock County—William E. Brown, Lawrence H. Goodman, Ralph E. Rasor, Harold K. Treece, Frank M. Wiseley.

Hardin County—William F. Binkley, Richard A. Dietrich, Floyd M. Elliott.

Harrison County—James Z. Scott.

Henry County—Thomas F. Tabler, Edwin C. Winzeler.

Highland County—John G. Anderson, J. Mar-

Distinguished Guests at The Council Dinner



At the head of the table for The Council dinner on Tuesday were the following, l. to r.: Dr. Edward J. McCormick, OSMA and AMA Past-President; Dr. H. M. Platter, OSMA Past-President and Secretary of the State Medical Board; Dr. David B. Allman, President of the AMA; Dr. Robert S. Martin, OSMA President; Dr. George A. Woodhouse, Incoming OSMA President; and Dr. Richard L. Meiling, at that time immediate Past-President of the Association. In the right foreground is Dr. E. O. Swartz, a Past-President.

tin Byers, Robert G. Claeys, Walter Felson, Clifford G. Foor, Lena B. M. Holladay, Glendon E. Parry, Jacob Wacker, Richard C. Wenrick.

Hocking County—Jan S. Matthews, Lethia Wood Starr.

Holmes County—Adam J. Earney, Neven P. Stauffer.

Huron County—Wilfred B. Dodgson, Otto F. Lanka, Owen J. Nicholson.

Jackson County—Clarence C. Fitzpatrick, J. L. Frazer.

Jefferson County—Stanley L. Burkhardt, Carl F. Goll, Sanford Press, Wilmer H. Rogers.

Knox County—Robert L. Eastman, George B. Imhof, Henry T. Lapp, Raymond S. Lord, James C. McLarnan, William L. Mahaffey.

Lake County—Benjamin S. Park, George R. Smith.

Lawrence County—Anne M. Alstott, Leo S. Konieczny, Harry Nenni, George N. Spears, Charles E. Vidt.

Licking County—A. S. Burton, Edward A. Carlin, Geraldine H. Crocker, Gerald A. Erhard, James K. Nealon, Howard H. Peppel, Arnold D. Piatt, Raymond G. Plummer, Grover B. Swoyer, J. R. Wells.

Logan County—Douglas W. Beach, George H. Freetage, Hobart L. Mikesell, Warren F. Mills, John J. Roget, Joseph G. Springer, John B. Traul.

Lorain County—Wilbur K. Brubaker, John Halley, Henry E. Kleinhenz, L. C. Meredith, Ben V. Myers, John W. Newman, Gordon A. Smith, James T. Stephens, George R. Wiseman.

Lucas County—Bernard Botsch, Porter Bruce Brockway, Henry A. Brunsting, Donald K. Cameron, Henry D. Cook, Edward L. Doermann, Henry P. Drake, Crawford L. Felker, James C. Fries, Edmond F. Glow, Walter H. Hartung, Jr., Richard Hotz, David M. Katchka, Orrin C. Keller, J. Lester Kobacker, Adelbert J. Kuehn, David K. Levin, Edward J. McCormick, Robert W. Muenzer, J. Robert Navarre, Edward F. Ockuly, Frederick P. Osgood, Frank F. A. Rawling, John L. Roberts, Rexford P. Rutter, Rolland E. Scherbarth, Max T. Schnitker, Maurice A. Schnitker, Charles F. Shook, Howard E. Smith, Gerald Stark, Earl F. Ward, Jr., Randolph P. Whitehead.

Madison County—Sol Maggied.

Mahoning County—Edgar C. Baker, William H. Evans, Sidney I. Franklin, Louis J. Gasser, Carl A. Gustafson, Francis G. Kravec, Arthur T. Laird, Harlan P. McGregor, Paul J. Mahar, William L. Mermis, Gordon G. Nelson, Stephen W. Ondash, C. Edward Pichette, Asher Randell, Fred G. Schlecht, Ivan C. Smith, Craig C. Wales, William P. Young.

Marion County—John T. Boxwell, John A. McNamara, Frederick T. Merchant, Thomas N. Quilter, Robert L. Stuber, Glenn E. Willoughby.

Medina County—Richard W. Avery, William

G. Halley, John L. Jones, Nevin J. M. Klotz, H. T. Pease.

Meigs County—Selim J. Blazewicz, Raymond E. Boice, Roger P. Daniels.

Mercer County—Louis J. Finkelmeier, Terry J. Kerrigan, George H. McIlroy, James J. Otis.

Miami County—William H. Adkins, Deane B. Armour, E. Paul Foy, John W. Gallagher, Robert L. Girouard, Berton M. Hogle, Glen S. Hogle, Dale A. Hudson, Maynard C. Kiser, Kenneth F. Lowry, Edwin F. Luh, Ernest T. Pearson, E. G. Puterbaugh, Harry E. Shilling, Dale R. South, Jr., William T. Wilkins, Jr., Gerard F. Wolf, George A. Woodhouse, Ralph D. Yates.

Montgomery County — William Abramson, Arnold Allen, Everett E. Archdeacon, Kenneth D. Arn, Lee R. Ashmun, Sterling H. Ashmun, Lynne E. Baker, Herman J. Bearzy, David L. Bernie, Roy S. Binkley, A. V. Black, Morton E. Block, Lewis Booker, Harry A. Bremen, Ian H. Brown, John R. Brown, Russell N. Brown, Robert A. Bruce, Herbert R. Cammerer, Arthur W. Carley, Everett F. Conlogue, Alva D. Cook, Lloyd H. Cox, Robert M. Craig, Sydney H. Dinkin,

R. C. Doan, R. Dean Dooley, John M. Duchak, Stuart R. Ducker, Stanley A. Earley, Jr., Philip A. Eckert, Harry Einhorn, Kenneth C. Evans, Fredericka F. Freytag, George H. Garrison, Edith Gitman, Peter A. Granson, Richard S. Graves, Francis V. Grice, William H. Hanning, Albert Hirsheimer, Nathaniel R. Hollister, Owen F. Hughes, Mason S. Jones, Raymond M. Kahn, Joseph S. Koehler, Jesse P. Kuperman, Joseph J. Larkin, William J. Lewis, Hans Liebermann, T. L. Light, Marion V. Lingle, Lawrence J. Lohr, William R. Love,

William L. McCowan, Samuel N. Maimon, G. E. Meyer, Jerome H. Meyer, Kenneth L. Meyers, Burton G. Must, Thomas E. Newell, Julius Ohlmann, George L. Parkin, C. Clarkson Payne, Charles B. Phillips, Merrill D. Prugh, Wallace E. Prugs, Forest F. Radcliff, Jr., James A. Rodeghero, Norman L. Rose, Louis Ryterband,

James L. Sagebiel, Burt E. Schear, Harry B. Schiffer, Hortense B. Schmitz, William J. Shine, William L. Slagle, Eldrin W. Smith, Norman F. Stambaugh, Henry L. Strohmeyer, Wallace B. Taggart, Stanley Vangrov, James M. Walters, Allan L. Wasserman, Thomas A. Wetaver, Jr., Sylvan L. Weinberg, Charles E. Wenyon, Robert Alan Wickham, Joseph M. Wilson, Giles Wolverton, John R. Woodruff, Robert E. Zipf.

Morgan County—Henry Bachman.

Morrow County—William S. Deffinger, Joseph P. Ingmire, Francis W. Kubbs.

Muskingum County—J. Herbert Baim, Walter B. Devine, Paul A. Jones, A. C. Lawrence, Robert S. Martin, Alfred C. Ormond, Fred W. Phillips, Earl B. Zurbrugg.

Ottawa County—George A. Boon, Cyrus R. Wood.

Paulding County—Doyt E. Farling.

Perry County—M. P. Clouse, Sydney N. Lord.

Pickaway County — Edward L. Montgomery, Frank R. Moore, Robert G. Smith.

Pike County—Robert M. Andre, George W. Cooper, Cecil L. Grumbles.

Portage County—Edgar A. Knowlton, Edward T. Meacham, Myron S. Owen, Myron W. Thomas.

Preble County—C. J. Brian, Charles E. McKinley, Everett P. Trittschuh.

Putnam County—Milo B. Rice.

Richland County—Russell H. Barnes, C. H. Bell, Rundle D. Campbell, Charles F. Curtiss, Carl R. Damron, Carroll E. Damron, Joseph B. Edelstein, Oscar W. Klein, Ernest B. Mainzer, Lizabeth S. Mainzer, Walter A. Massie, Joseph E. Seibert, Charles L. Shafer, Pearl O. Staker, Lawrence C. Thompson, Albert H. Voegele, Francis M. Wadsworth, Harry Wain.

Ross County—Edwin H. Artman, William J. Corzine, Harold M. Crumley, Ernest B. Cutlip, John W. Franklin, L. T. Franklin, William M. Garrett, Ralph W. Holmes, Walter E. Kramer, David McKell, Paul F. MacCarter, Jr., James R. Manchester, M. Dow Scholl, Byron Stinson, Robert E. Swank, Joseph Utrata.

Sandusky County—John C. Bates, C. L. Fox, Robert C. Fox, Anthony C. Rini, Glenn H. Walker.

Scioto County—Dow L. Allard, Donald M. Appleton, Walter A. Braunlin, Robert N. Counts, Clyde M. Fitch, William J. Hartlage, L. B. Hatch, W. C. Hugenberg, A. P. Hunt, Milton Levine, Elizabeth B. Long, James P. McAfee, Carter L. Pitcher, Jerome M. Rini, Henry F. Rogowski, Marie B. Rogowski, William E. Scaggs, William M. Singleton.

Seneca County—Henry L. Abbott, Walter A. Daniel, Olgierd C. Garlo, Robert R. Schwalenberg, Jr.

Shelby County—R. W. Alvis, Clayton B. Conover, H. Eugene Crimm, Boyd L. Mahuron, George J. Schroer, Edward P. Sparks, Jr.

Stark County—Robert H. Angerman, Edmund Beshara, George F. Cain, Alfons Cecys, John E. Dougherty, Marion M. Estes, Mark G. Herbst, Leslie L. Lawrence, Charles O. Paradis, Otto L. Plaut, John R. Seesholtz, Richard G. Spitzer, L. D. Stoner, Grace F. Thomas, John F. Thompson,

Robert E. Tschantz, John B. Walker, Howard B. Weaver, William A. White, Jr.

Summit County—Paul A. Davis, Reynold P. Desman, Arthur Dobkin, Joseph J. Eckert, Floyd J. Fowler, A. William Friend, James R. Hodge, Keith C. Keeler, James G. Kramer, Donald I. Minnig, H. E. Muller, Howard O. Musser, Carl C. Nohe, William Onest, Reuben R. Pliskin, Fred M. Rankin, Jr., Robert T. Rowe, Richard H. Stahl, Donald M. Traul, James T. Villani, Edward L. Voke, Frank M. Warner, Laurence M. Weinberger, Aubrey S. Willacy, Rex H. Wilson.

Trumbull County—E. G. Caskey, Frank T. Kandrac, E. G. Kyle, Clyde W. Muter, Raymond H. Ralston, Aubrey L. Sparks.

Tuscarawas County—Jurgis Balciunas, Chester A. Bennett, D. M. Ceramella, C. Raymond Crawley, Edgar C. Davis, Jr., Clark M. Dougherty, Philip T. Doughten, Paul D. Hahn, Joseph W. Hamilton, James R. Martin, Vincent C. Nipple, William C. Roche, Arthur J. Stevenson, Herbert F. VanEpps, George D. Woodward.

Union County—Walter R. Burt, Fred C. Callaway, Malcolm MacIvor, E. J. Marsh, Lloyd E. Moore, James W. Sampsel, James M. Snider, May B. Zaugg, Paul R. Zaugg.

Van Wert County—Edwin W. Burnes, James R. Jarvis.

Vinton County—Herbert D. Chamberlain.

Warren County—Thomas E. Fox, O. Williard Hoffman, Orville L. Layman, D. P. Ward.

Washington County—Kenneth E. Bennett, Ford E. Eddy, George E. Huston, Edgar Northrup, Jr., William R. Stewart.

Wayne County—A. Burney Huff, Richard W. Reiman.

Williams County—Paul G. Meckstroth, John R. Riesen.

Wood County—Sigmund Kosewick, Paul F. Orr, Roger A. Peatee.

Wyandot County—Talmadge R. Huston, Allen F. Murphy, Herschel A. Rhodes.

New Catalog Lists 87 Medical Films Available

A revised list of films available through the AMA motion picture library has been prepared and copies are available upon request from Motion Pictures and Medical Television of the AMA.

This new catalog lists 87 medical films suitable for showing to medical societies, hospital staff meetings, and other scientific groups. It also lists 5 health films of interest to physicians who may be called upon to speak before lay audiences.

Do You Have Any Clews To Missing Film?

A film which was shown by Dr. James M. Sutherland at the joint session of the Section on Pediatrics and Section on Radiology on Tuesday morning, April 15, at the 1958 Annual Meeting, Cincinnati, disappeared and, todate, Dr. Sutherland has been unable to locate it. It carried an adhesive tape label "Infant Wilkins." It consisted of a strip of black and white X-ray and a Kodachrome of an infant in an incubator.

Should any member have knowledge of the whereabouts of the film, he would be doing Dr. Sutherland a great favor by getting in touch with him at the University of Cincinnati College of Medicine, as the film was an original and no copy is in existence.

Miami County Medical Society Pays Tribute to Dr. Woodhouse for Continuing Service

The Miami County Medical Society at a meeting on May 1, attended by 75 members and guests, honored Dr. George A. Woodhouse, the new President of the Ohio State Medical Association and who had served that society as secretary-treasurer for more than 25 years prior to several years ago when he gave up that office in order to devote more time to OSMA and AMA activities.

The society surprised Dr. Woodhouse by presenting him with a radio and by adopting the following resolution of appreciation:

WHEREAS, A distinguished member of our Medical Society has just been inducted into the highest office of our State Medical Association, and

WHEREAS, This honor comes after many years of faithful service and able leadership on a local, state and national level, and

WHEREAS, The members of this Society appreciate his efforts in making Miami County Medical Society a prominent rural group, and

WHEREAS, Every doctor knows the sacrifice that is required to take an active part in organized medicine and the great importance of this work to the medical profession today,

THEREFORE, BE IT RESOLVED, that the Miami County Medical Society extend to George A. Woodhouse, President of the Ohio State Medical Association, our most sincere congratulations and best wishes for the big task that lies ahead in directing this great organization and, that he be made an honorary president of the Miami County Medical Society.

Adopted May 1, 1958.

The meeting started with a dinner, followed by a narrated film "By Jeep Around the World," a contribution of Cincinnati architect, Ted Baumiller.

Quite a number of members of the Shelby County Medical Society joined the Miami County physicians in this delightful evening.

Journal To Run Series of Articles on Physicians and Social Security, Preliminary To Member Poll This Coming Fall; Submit Material and Opinions If You Desire

SHOULD, or should not, physicians be covered by Old Age and Survivors Insurance under the Social Security Program?

All members of the Ohio State Medical Association will be polled on this question —probably in October. Such a poll was ordered by the House of Delegates at the 1958 Annual Meeting.

In the July, August and September issues of *The Ohio State Medical Journal* there will appear material—pro and con—on this subject. This was ordered by the House of Delegates at this year's meeting.

Members who may have material on either the pro or con side of this question or who may care to express their own opinions for publication may do so, by communicating with the Columbus Headquarters Office. This should not be regarded necessarily as assurance that the material or opinions submitted will be published as that will depend on how much material is received and its comparative value.

Watch for the articles starting in the July issue.

Premedical Education Group Holds Conference at Ohio Wesleyan

"Medicine and Religion" was the topic discussed at the third annual Spring conference sponsored by the Rice Foundation for Premedical Education on the campus of Ohio Wesleyan University, Delaware, Sunday, April 27. The Foundation is composed of physicians who took their undergraduate premedical training at Ohio Wesleyan.

Speakers at the morning session were: Dr. George T. Harding, III, Columbus, and Dr. Howard M. LeSourd, executive assistant to Dr. Norman Vincent Peale, New York City.

Following dinner, President Arthur S. Flemming of Ohio Wesleyan moderated a panel discussion. Panel members were: Dr. Claude S. Perry, Columbus, chairman of the Foundation; Rev. Sidney Mayer, executive secretary, Interboard Council, Ohio Conference of the Methodist Church; Dr. Frederick T. Merchant, Marion; Charles B. Mills, chairman of O. M. Scott & Sons, Marysville, and president of the Ohio Wesleyan Board of Trustees; Dr. Harding and Dr. LeSourd.

The program was arranged by Dr. Perry, Prof. William A. Manuel, chairman of the Chemistry Department and Premedical Advisor at Ohio Wesleyan, and George H. Saville, Director of Public Relations, Ohio State Medical Association, a member of the Foundation's executive committee.

Approximately 100 physicians, their wives and premedical students attended the conference.

Do You Know? . . .

Dr. H. W. Lawrence, medical director of the Proctor and Gamble Company, Cincinnati, was elected President of the Industrial Medical Association at the 13th National Industrial Health Conference in Atlantic City. Dr. Lawrence is associate professor of industrial medicine University of Cincinnati, and recently was appointed to the OSMA Committee on Industrial Health and Workmen's Compensation.

* * *

Dr. J. W. Wilce, Columbus, spoke before a session of the Wisconsin State Medical Association annual meeting on the subject, "Medical Aspects of the Current Athletics and Sports Picture." Dr. Wilce reported on a 27-year study of athletes which covered cardiac effects of athletic stress. A member of long standing on the Ohio State University student health service, he is a member of the OSMA Committee on School Health.

* * *

Dr. Alan R. Moritz, professor of pathology and director of the Institute of pathology at Western Reserve University, was elected president of the American Association of Pathologists and Bacteriologists at its meeting in Cleveland April 24.

* * *

Dr. George M. Leiby, manager of the Veterans Administration Research Hospital, Chicago, has been named area director of professional services in the Columbus, Ohio, VA area medical office.

Auxiliary Report to OSMA . . .

Review of Year's Activities Are Presented by Auxiliary President to The OSMA House of Delegates at the 1958 Annual Meeting in Cincinnati

By MRS. V. R. FREDERICK, Urbana

I AM indeed happy to be able to be a participant in this "first"— the first report made by your Auxiliary to the House of Delegates to the Ohio State Medical Association.

We feel we are an Auxiliary to the greatest profession in the world—and we attempt to perform the real function of an Auxiliary, i. e. to act under the direction, with the permission and with the aid of the Medical Association.

But, first of all, I would be extremely remiss in my duty if I did not express the Auxiliary's thanks to you for your generous financial assistance. And, I have evidence to prove that we are as all women! We could hardly wait to spend part of it!

This is "Rx for County Auxiliaries," a guide and tool which will be given to each county Auxiliary, in order that our efforts on your behalf may become even more worthwhile.

Our most earnest thanks go to our advisors, representing you and The Council, who have given of their time and wisdom during the past year.

Of necessity, part of this "report" to you will be statistical, in that we would like to have you know more about us.

In Ohio, we have 60 organized county Auxiliaries, with just over 5000 members. Obviously, to make our work unified and representative of all the Medical Societies, we hope in coming years to have Medical Auxiliaries in every county. For, only then, will we be doing all we are capable of doing for you, the Ohio State Medical Association—and that is our one objective. Our only reason for being.

PR for Medicine

The activities of the Auxiliary are carried out in many fields, but all carry out our aim to further good public relations for the medical profession. We have worked in the fields of civil defense, safety, legislation, and mental health, among others; and we have used the mediums of newspapers, TV, radio, and other visual education techniques to create interest among lay-people in these fields.

Almost half of our county organizations have assisted hospitals in their communities. Many Auxiliaries have invited dental, druggist, and bar auxiliaries to their meetings, to further our public relations with these groups.

Throughout the state, Medical Auxiliaries have distributed over 60,000 Health Wallet Cards and 30,000 Family Health Record Books.

However, we have, during 1957-58, placed special emphasis on certain projects at the request of our parent bodies—the Ohio State Medical Association and the American Medical Association.



Mrs. V. R. Frederick, President of the Woman's Auxiliary, presents the Auxiliary Annual Report before the House of Delegates.

First, the AMA, from the very beginning of an Auxiliary, has asked us to encourage the distribution of *Today's Health* magazine, the one authorized medical publication directed at the layman. This year, the Auxiliary in the state of Ohio has been credited, to date, with 4871 points. (One point is earned by each one year subscription.)

We know that you recognize the importance of this magazine to your own patients. Therefore, we have urged that it be put in doctors'

offices, dentists' offices, beauty parlors, and other public waiting rooms.

Many Auxiliaries have purchased subscriptions for their schools and hospitals. One Auxiliary is now including the cost of a subscription for each member of their yearly dues.

We have discovered one fact, which I'm sure you already know, and that is that the lay-reader is indeed interested in *Today's Health,* once he has been introduced to it. He wants to know about his health—it's a matter of life or death to him!

Also, in response to the request made by this House of Delegates in 1957, we have encouraged and sponsored the Essay Contest of the Association of American Physicians and Surgeons, concerning the private practice of medicine and the American way of life. Ohio has had over 300 entries in this contest, four of which have been selected to be sent on to the national level.

One county Auxiliary offered cash awards to students in their community to encourage participation. It is our hope that such a practice will become more general in future years.

Student Nurse Aids

And, the Auxiliary's activities in recruiting students in the fields of nursing, medical technicians, medical social workers, etc., in Ohio is particularly outstanding.

For example, did you know that Medical Auxiliaries throughout the state offer 41 scholarships to students in these fields? That there are 23 loan funds available through Auxiliaries? That 20 outright awards are made by Auxiliaries to deserving students in professions allied with the field of medicine? Did you know that 20 counties sponsor one or more Future Nurse Clubs in their high schools?

In addition, 12 smaller counties employ other recruitment methods in their counties. Every Auxiliary in the state of Ohio is doing something in the field of recruitment!

We are a working public service organization —working in your interest, by working to secure better health for all our citizens.

And so, lastly, perhaps the most tangible evidence of our work, is in the field of American Medical Education Foundation, interested in promoting the training of future doctors and thus better medical care. With only one or two exceptions, every organized county Auxiliary in Ohio has contributed to this cause. And, at the personal request of Dr. Martin, on your behalf, we will be stressing Medical Education Week, April 20-26 throughout the state. Through special emphasis, we shall endeavor to help the layman recognize the importance of good medical education in the interest of good medical care.

The National goal for contributions to AMEF is $150,000—and during 1957-58, the Woman's Auxiliary to the Ohio State Medical Association has contributed, to date, more than $13,000.00. We hope to reach Ohio's goal of $15,000 by the last of May. Our congratulations go to Mrs. Warren F. Mills of Bellefontaine for her outstanding work in this area.

This, then, is the most tangible evidence I can present to you of our work for you. This, we feel, is one of our greatest achievements.

We are an Auxiliary. We are "at your service." It is our aim to do whatever you ask, whenever you ask it. For we wish to uphold the same high standards you represent in the Ohio State Medical Association.

Dr. W. H. Willis, Lake County Health commissioner, has resigned effective the end of the year to return to the African mission field. He was medical missionary for the Congregational Church from 1930 to 1940.

Send Your License Number To BWC; Don't Penalize Yourself

Several hundred Ohio physicians are unnecessarily slowing up payment of their fees in industrial accident cases, according to the Bureau of Workmen's Compensation. These physicians have failed to furnish BWC with the number of their State Medical Board license as requested by BWC last November. This request also was publicized in The Ohio State Medical Journal and the OSMAgram.

BWC has mechanized its procedure for payment of medical bills. Since punch equipment is used, it is necessary to identify each physician by a code number. This code number is based on the number of his State Medical Board license. The system has speeded up payment of medical fee bills.

If you haven't sent in your Medical Board license number to the Bureau of Workmen's Compensation, do so immediately. You're not only penalizing yourself by delaying this relatively simple chore, you are causing extra clerical work at BWC that could well be used for other purposes. The address is: State Office Bldg., Columbus, 15.

Woman's Auxiliary Annual Meeting . . .

A Busy Three Days of Activities Marked the Program and Business Sessions of Doctors' Wives During Their Convention in Cincinnati

WOMEN'S activities began on Monday, April 14, with the pre-convention board meeting in the early afternoon. During recess from 3:00 to 5:00 p. m., the Auxiliary to the Academy of Medicine of Cincinnati was hostess for a tea to which all Auxiliary members were invited.

Highlight of Monday evening was the report of the year's activities given before the House of Delegates of the State Association by Mrs. V. R. Frederick, president. This was a first for the Auxiliary.

Official business sessions began Tuesday morning, April 15, with Mrs. Frederick presiding. The Reverend John S. Queen, Dayton, brother of Mrs. Frederick, gave the invocation. After the pledge of allegiance to the flag and the pledge of loyalty to the Auxiliary, greetings were extended to the delegates and guests by Dr. George Schwemlein, president of the Academy of Medicine of Cincinnati; Mrs. Gaston B. Hannah, president of the Auxiliary to the Cincinnati Academy; and Mrs. John Pond, president-elect of the Champaign County Auxiliary.

After several reports and the President's address, recess was called and the annual Doctors' Day luncheon was held in the Hotel Sinton Ballroom. This luncheon honored Dr. Robert Martin, President of the State Association; Dr. George Woodhouse, OSMA President-Elect; Dr. George Schwemlein, President of the Academy of Medicine of Cincinnati; Dr. James Jarvis, Dr. C. L. Pitcher, and Dr. Carl Gustafson, Advisory Committee; Dr. Merrill Prugh, AMEF chairman for the OSMA; Dr. and Mrs. Frederick and Dr. and Mrs. C. H. Bell. A beautiful program of songs, both popular and operatic, was given by Marian Spelman.

Business sessions reconvened at 2:30 p. m. ending with a three-part program entitled "Maybe This Will Help" for county Auxiliary members. In the evening several members of the Gavel Club (past-presidents) met for dinner and informal discussions about Auxiliaries.

Wednesday Program

Wednesday morning's sessions opened with the invocation by the Reverend Malcolm Hooker, Urbana. This session was highlighted by the presentation of many certificates, given county auxiliaries for excellent work in AMEF, *Today's Health* and credits and awards.

Recess was followed by cocktails and luncheon. The H. & S. Pogue Company presented a fashion show of the latest styles which was enjoyed by all as shown by spontaneous applause.

The following were honored at the Wednesday luncheon: Mrs. Paul C. Craig, president of the Woman's Auxiliary to the American Medical Association; past-presidents and honorary members of the Woman's Auxiliary to the OSMA; state board members; and out of state and other guests—Mrs. J. Andrew Bowen, president of the Woman's Auxiliary to the Kentucky State Medical Association; Mrs. Robert Reagan, president-elect, Woman's Auxiliary, Michigan; Mrs. Edward P. Dennis, president Woman's Auxiliary, Pennsylvania; Mrs. J. C. Huffman, president, and Mrs. G. Thomas Evans, president-elect, Woman's Auxiliary, West Virginia, and Mrs. H. V. Gieringer, president of the Woman's Auxiliary to the Ohio State Dental Association.

The Wednesday afternoon business session was called to order. The Auxiliary was honored to have the three advisors from the OSMA at this meeting.

After the reading and adoption of several resolutions, Mrs. Paul C. Craig, national president, installed the new officers. Mrs. Frederick presented the gavel and president's pin to Mrs. C. H. Bell, the new president, and Mrs. A. Paul Hancuff, president of the Gavel Club, presented the past-president's pin to Mrs. Frederick.

After an inspiring and instructive inaugural address by Mrs. Bell, the Eighteenth Annual Convention of the Woman's Auxiliary to the OSMA was adjourned.

Appreciation for planning and hospitality in Cincinnati was expressed to the convention chairmen, Mrs. Charles W. Hoyt and Mrs. Carl F. Schilling.

On Thursday, April 17, an innovation, brunch and a post-convention board meeting was open to all auxiliary members.

Officers Elected

The roster of newly elected officers with their addresses is listed on page 697 of this issue.

District directors are the following: First, Mrs. Herbert Warm, Hamilton; Second, Mrs. R. D.

Hendrickson, Xenia; Third, Mrs. Stephen P. Churchill, Kenton; Fourth, Mrs. C. J. A. Paule, Toledo; Fifth, Mrs. James N. Wychgel, Shaker Heights; Sixth, Mrs. Edward Bauman, Warren; Seventh, Mrs. C. F. Goll, Steubenville; Eighth, Mrs. J. R. Wells, Newark; Ninth, Mrs. George W. Cooper, Waverly; Tenth, Mrs. Rivington Fisher, Columbus; Eleventh, Mrs. John L. Jones, Medina.

Committees

Standing Committee Chairmen and Directors-at-Large are the following: Historian-Archives, Mrs. William H. Evans, Youngstown; Legislation, Mrs. Harry L. Fry, Cincinnati; Program, Mrs. Herbert F. Van Epps, Dover; Public Relations, Mrs. Lester W. Sontag, Yellow Springs; Publicity, Mrs. William J. Horger, East Liverpool; *Today's Health* and *Bulletin,* Mrs. Morton E. Block, Dayton.

Special Committee chairmen are: American Medical Education Foundation, Mrs. Geo. W. Cooperrider, Columbus; Civil Defense, Mrs. Francis Visconti, Fremont; Convention chairman, Mrs. Homer Anderson, Columbus; Convention co-chairman, Mrs. Edward Turner, Columbus; Credits and Awards, Mrs. S. L. Meltzer, Portsmouth; Members-at-Large, Mrs. M. S. Huber, Bettsville; Mental Health, Mrs. Philip T. Doughten, New Philadelphia; Nominations, Mrs. V. R. Frederick, Urbana; Nurses Loan Fund and Recruitment, Mrs. Joseph Hertsberg, Toledo; Parliamentarian, Mrs. A. Paul Hancuff, Maumee; Reference and Revisions, Mrs. Karl F. Ritter, Lima; Safety, Mrs. Walter Kramer, Chillicothe; Television-Radio and Visual Education, Mrs. Earl Young, Youngstown.

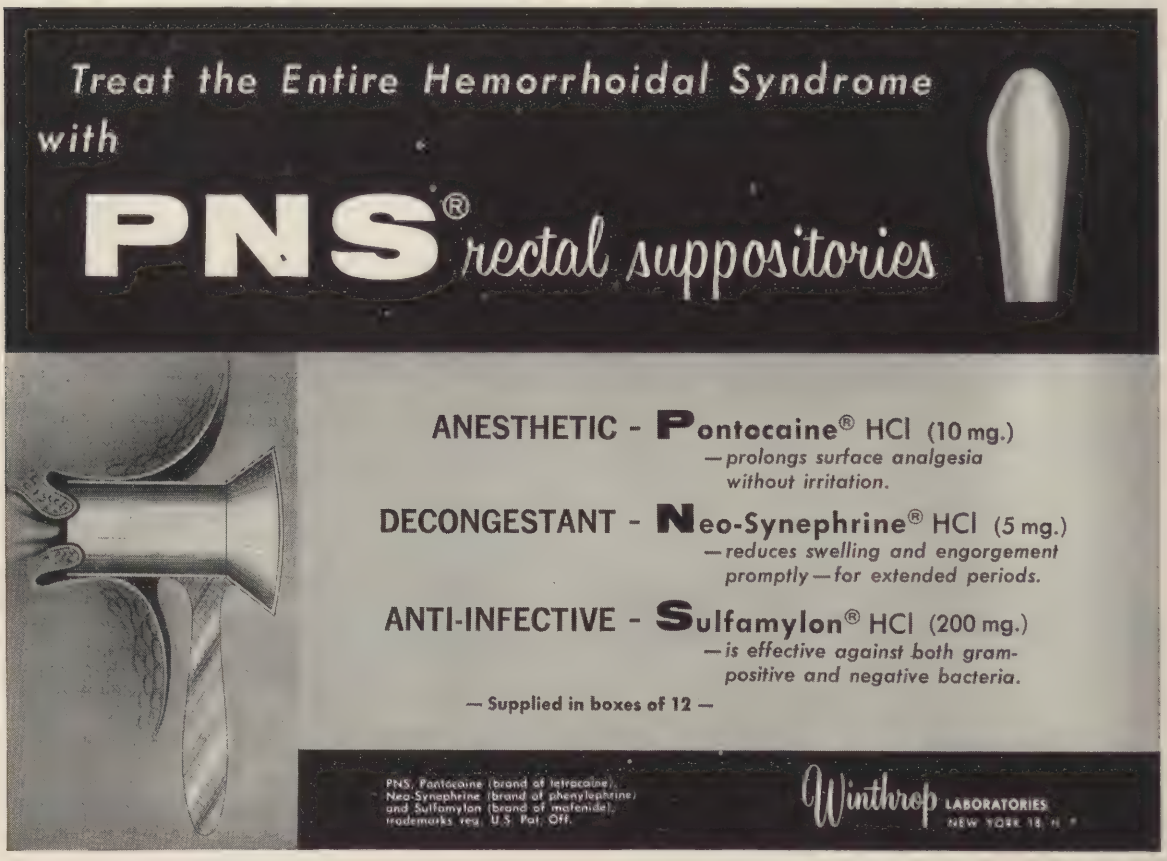
Auxiliary News Staff: Editor, Mrs. N. M. Reiff, Washington C. H.; Circulation Manager, Mrs. J. Martin Byers, Greenfield; Advertising Manager, Mrs. Boni Petcoff, Toledo.

Advisory Committee (all members of The Council of the OSMA): Dr. C. L. Pitcher, Portsmouth, chairman; Dr. H. T. Pease, Wadsworth, and Dr. C. A. Gustafson, Youngstown.

Cincinnati Area G. P's.

"E. N. T. Problems and Allergic Respiratory Disease" was the subject of a seminar presented by the Southwestern Ohio Society of General Physicians at the College of Medicine Auditorium in Cincinnati.

Dr. Hugh H. Hussey, who was elected to the A.M.A. Board of Trustees in June 1956, will become dean of the Georgetown University Medical School on July 1. He has been serving as professor of medicine and head of the department.

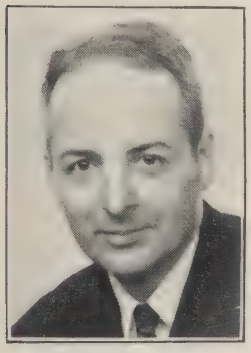


Ohioan New Head of HEW . . .

Arthur S. Flemming Resigns As Ohio Wesleyan University President To Accept Appointment as Secretary of Important Federal Department

DR. ARTHUR S. FLEMMING, president of Ohio Wesleyan University, Delaware, has been named by President Eisenhower to succeed Marion B. Folsom as Secretary of Health, Education and Welfare. This is subject to confirmation by the Senate.

A native of Kingston, N. Y., Flemming graduated at Ohio Wesleyan in 1927, followed by graduate training at American University and George Washington University in Washington, D. C.



Dr. Flemming

Following 10 years as instructor, Director of the School of Public Affairs and Executive Officer of American University, he was appointed a Republican member of the U. S. Civil Service Commission in 1939, a post he held until 1948 when he became President of his Alma Mater.

During World War II, Flemming was chairman, Management-Labor Policy Committee, War Manpower Commission. He was a member of the Commission of Organization of Executive Branch of Government (Hoover Commission) 1947-49, 1953-55. He also held several other important Federal committee appointments in the field of manpower and personnel management.

Flemming was on leave from the presidency of Ohio Wesleyan University from 1953 to 1957, during which he was Director, Office of Defense Mobilization, a statutory member of the National Security Council, and by invitation of President Eisenhower, a participant in meetings of the Cabinet.

Numerous Responsible Posts

Among the many non-governmental organizations which Flemming has served are: American Heart Association; President's Committee on Employment of the Physically Handicapped; National Advisory Council—Welfare of the Blind, Inc.; Ohio Society for Crippled Children—1957 Easter Seal chairman; Administrative Committee of the Commission on Higher Education; National Council of Churches; Chairman, St. Lawrence Waterway Committee; Chairman, Commission on Survey of Dentistry of the American Council on Education; Chairman, Ohio Citizens Committee on Highways and National Fund Vice Chairman in Ohio for the American Red Cross.

The recipient of many honorary degrees for his attainments from universities throughout the country, and the Medal of Freedom from President Eisenhower for service as Director of the Office of Defense Mobilization, 1953-57, Flemming assumes the important Cabinet post of Secretary of Health, Education and Welfare, with a distinguished record of accomplishment in the fields of education and public service.

Average Citizen Visits Doctor Nearly Five Times a Year, Survey Shows

The American people visited their physicians during the months of July, August and September, 1957, at a rate of almost five times a year, according to data gathered through household interviews by the U. S. National Health Survey.

The report, entitled "Preliminary Report on Volume of Physician Visits, United States, July-September 1957," is the first of a continuing series.

Future reports in the series will deal with disability, hospitalization, injuries, chronic illnesses and related health matters.

The report on physician visits points out that the interviews occurred at a time of year when people are normally least likely to call the doctor. The report notes that last year, however, respiratory diseases were probably at above-average levels.

Nine out of 10 of the physician visits were in the physicians' offices, the report shows.

Persons living on farms used physicians' services during the quarter at a rate of 3.6 visits a year, compared with 4.5 for the rural nonfarm population, and 5.1 for the urban population. Visits for general check-ups were somewhat less frequent for the farm population than for either of the other two residence groups.

Health Survey reports are based on continuing nationwide household interviewing conducted for the Public Health Service by the U. S. Bureau of the Census, on a representative sample of the population.

Ohio Medical Indemnity . . .

Annual Report Shows Increase of More Than 123,000 Persons Covered By Blue Shield in Ohio During 1957; Directors and Officers Elected

OHIO MEDICAL INDEMNITY, INC., Ohio's Blue Shield plan, which is sponsored by the Ohio State Medical Association, ended the year 1957 with 920,889 contracts in effect, covering 2,284,564 persons, stockholders of the company were advised at the annual stockholders meeting on April 23 at the home office, 3770 N. High Street, Columbus. This represented an increase of 49,606 contracts and 123,447 persons covered during 1957. Nationally, OMI continues as the fourth largest Blue Shield plan. The 73 plans of the country acquired 2,676,000 new members during 1957, making the year-end total 41,479,000.

At the annual stockholders meeting, directors for the ensuing year were elected and the new directors, meeting subsequently, elected officers as follows:

Officers Elected

President, Dr. H. M. Clodfelter, Columbus; vice-president, Dr. R. Dean Dooley, Dayton; executive vice-president, Mr. Charles H. Coghlan, Columbus; secretary - treasurer, Mr. Charles S. Nelson, Columbus; assistant secretary - treasurer, Mr. Frank W. Van Holt, Columbus.



H. M. Clodfelter, M. D.
New OMI President

Dr. Clodfelter succeeds Dr. C. C. Sherburne, Columbus, who retired from the board after serving since the organization of OMI in 1946. Others who retired after having served on the board since the beginning of the company were Dr. Carll S. Mundy, Toledo, who served as president several years ago, and Dr. Robert T. Allison, Jr., Akron, who had served many years on the executive committee.

Directors elected to succeed Drs. Sherburne, Mundy and Allison were: Dr. Robert S. Martin, Zanesville; Dr. Perry R. Ayres, Columbus; and Dr. Gordon M. Todd, Toledo.

Directors re-elected in addition to Dr. Clodfelter and Dr. Dooley were: Mr. D. A. Endres, Youngstown; Dr. D. W. English, Lima; Mr. Clair E. Fultz, Columbus; Dr. Charles N. Hoyt, Chillicothe; Mr. Fred D. Learesy, Columbus; Msgr. Robert A. Maher, Toledo; Dr. J. Stewart Mathews, Cincinnati; Mr. Richard L. Ross, Columbus; Dr. George L. Sackett, Cleveland; Dr. L. Howard Schriver, Cincinnati; Mr. Harold W. Slabaugh, Akron; Dr. Robert G. Smith, Circleville; Mr. David L. Temple, Dayton; Mr. James V. Walker, Columbus; Dr. Edmond K. Yantes, Wilmington; Dr. Sterling C. Yinger, Springfield.

President Clodfelter appointed the following as members of the executive committee: Dooley, chairman, Hoyt, Sackett, Yantes, Yinger, Smith, Martin, Fultz and Slabaugh.

Other committees appointed by President Clodfelter are:

Future and Past Coverage Committee: Dr. Edmond K. Yantes, Chairman; James V. Walker, Dr. D. W. English, Dr. R. G. Smith, Dr. Perry R. Ayres, Dr. J. Stewart Mathews.

Extended Benefits and National Enrollment Committee: Dr. Charles N. Hoyt, Chairman; Dr. Starling C. Yinger, Dr. L. Howard Schriver, Msgr. Robert A. Maher, Fred D. Learey, Dr. Gordon M. Todd.

Investment Committee: Clair E. Fultz, Chairman; Dr. H. M. Clodfelter, Frank W. Van Holte, Dr. Starling C. Yinger.

Blue Cross and Public Relations Committee: Harold W. Slabaugh, Chairman; Dr. George L. Sackett, D. A. Endres, Dr. Robert S. Martin, David L. Temple, Richard M. Ross.

In his report to the board of directors, Executive Vice-President Coghlan reviewed the activities of OMI during 1957 and commented on some of the projects to be undertaken by the company during the ensuing year. The following is abstracted from Mr. Coghlan's report and a financial report given by Mr. Van Holt, assistant secretary-treasurer:

For the last two years new groups have been enrolled by OMI in either the Standard or the Preferred Package Plans. Both contracts provide the same scope of benefits but with different payment and premium schedules.

In the midyear 1956 a conversion program was started to upgrade existing contracts from surgical only to the package benefits of surgery, anesthesia and in-hospital medical care.

At the end of 1957 a substantial number of

these contracts had been converted. As an example: Of 728,000 Standard Contracts in force December 31, 1957, over 512,000 were Standard Package. The remaining 216,000 are being converted as time and circumstances permit.

The success of this conversion has improved OMI's public and professional relations. Previously, many subscribers thought they had anesthesia and in-hospital medical benefits, filed claims and received a letter of rejection. Now such claims are being paid.

Ohio Medical also has available a limited Non-Group Contract for "over-the-counter" sales. It is restricted, with waiting periods on many elective operations and does not carry maternity benefits. However, it is for sale at any time, to anyone (no age limit), and has been a help to those individuals who have not been able to secure protection through group arrangements. In 1957, 5,992 additional Non-Group Contracts were added, bringing contract count in this category to 17,841.

Enrollment Problems

In 1957 there arose growing dissatisfaction with Ohio Medical benefits among subscribers and within the medical profession.

In 1952, as a result of a survey on doctors' charges versus payments OMI introduced its Preferred Contract. The benefits for surgical procedures were greater and anesthesia was incorporated in this contract. The sale of this contract has been disappointing. It has been on the market for six years and only 18 per cent of OMI membership have these additional benefits.

The continued rise in costs of all segments of the economy, including medicine, pushed the Standard Contract lower on the ladder. The goal of providing a payment to the subscriber sufficiently high enough to pay a substantial part of his medical bill became farther away.

In '57 actions were started to correct this condition and to regain the support of both subscribers and physicians.

It was decided to eliminate the inadequate Standard Contract and to replace it with a contract providing benefits commensurate with current physicians' charges. To determine current charges OMI conducted a survey in which subscribers were asked to indicate what they had been charged. From the results of this survey OMI will develop a new contract.

The sale of this new contract to new groups will not be difficult since this will be the only "product" OMI will have for sale.

The conversion of 2¼-million members to the new contract, however, will not be an easy task.

The successful conversion to this better contract in the coming months is going to require the utmost co-operation and support of the medical profession, OMI officials are certain. OMI will ask physicians to recommend the higher coverage to their patients.

There has been a demand for expansion of coverage and for "extended benefits" contracts. These requests are prompted by the competition of a variety of contracts now being offered by the insurance industry. The position taken by Ohio Medical in this relationship is that the subscribers must first be provided with adequate basic benefits before launching into "extended benefits."

Future Activity

OMI officials have met with committees from radiology and pathology, and OMI is now developing coverage for diagnostic x-ray and pathology services. This contract will be ready in the near future. The question of whether to offer it on a rider basis or incorporate it into the basic contract will be discussed in an early meeting.

The change in the subscribers' contract to include certain surgical services by chiropodists and dentists will be accomplished soon.

Present plans provide that all subscribers will receive this benefit without an increase in premium.

The year of 1957 was an important year in the history of Ohio Medical. It brought out the recognition of existing problems and the decisions to correct them.

In the year 1957, Ohio Medical Indemnity had a gross premium income of $21,644,000.00, of which $17,713,000.00 was returned to subscribers in the form of claim checks. This represented a return of 81.84 per cent of the premium dollar. The sum of $2,234,000.00 was added to the general reserve, increasing this reserve to almost $12,000,000.00.

A review of the 73 Blue Shield plans in the country reveals that 1957 was almost a "break-even" year. The national percentage of utilization rose to 88.01 per cent. The utilization for Ohio Medical Indemnity for the first quarter of 1958 has increased to 83.48 per cent, which represents a 1.8 per cent increase over the first quarter of 1957.

In the year 1957 OMI paid a total of 318,171 claims. Currently, it is averaging nearly 28,000 claims per month, which is 2,500 more claims per month than the comparable period in 1957. The average claims paid per working day is 1,300, representing over $72,000.00 paid per day.

Gamma Globulin . . .

Reported Lack of Availability Explained by Health Director Who Draws Distinction Between That Furnished by Red Cross and Commercial Supply

THERE have been increasingly frequent inquiries of the state and local health departments by private physicians concerning the occasional lack of availability of gamma globulin. Because there is apparently a misunderstanding about this shortage, *The Journal* obtained the following facts from Dr. Ralph E. Dwork, director, Ohio Department of Health:

The free gamma globulin distributed is supplied entirely by the American Red Cross with the state and local health departments being responsible for equitable distribution. The state and local health departments are not empowered to purchase this material.

Because there has been a gradual decrease in the amount of blood processed, the supply of gamma globulin has been correspondingly lowered during the past two years so that at present it is approximately 80 per cent of what had been available before.

No Strict Rules

There are at present no strict rules governing the distribution in any local area since all requests in the past had been easily met and there usually had been a surplus available even under these circumstances. The decision for its proper use had been left mainly to the private physician requesting it and the ease with which he is able to obtain it varies with each local area.

The Ohio Department of Health has not as yet placed any formal restrictions as to the conditions under which the local health departments may fill requests, but it has indicated to them those conditions for which gamma globulin has known effectiveness and has requested that they check more carefully into the reasons for its use.

Why the Shortage

It is thought that the effects of the short supply of gamma globulin are being magnified by (1) an especially high incidence of measles this year; and (2) because physicians are employing it for purposes other than those for which it has known effectiveness such as repeated injections of patients who have recurrent respiratory illnesses. While the rationale of such ingenious therapeutic regimens may be theoretically sound, such use of a publicly distributed product in uncontrolled fashion can hardly be justified, especially if it makes this product unavailable for conditions where it has known efficacy, Dr. Dwork said.

At the present time, it is neither contemplated nor desired to regulate the distribution of gamma globulin more closely, but if the present shortage persists it may be necessary that local health departments require a formal accounting on an individual patient basis both as to the amount and reason for its use and to restrict its use to those conditions where its effectiveness has been proved.

The free gamma globulin is not made available on the basis of inability to pay but rather on the basis of its usefulness for a particular condition. The purpose of the health department in supplying this service is to see that it is made available on an equitable basis.

Ohio State Cites Two Physicians With Alumni Awards

Dr. Hugh G. Beatty, Columbus, and Dr. Howard F. Polley, Rochester, Minn., received the "Alumni Achievement Awards" of Ohio State University's College of Medicine.

Presentation was made by Dr. Charles A. Doan, dean of the college, at a luncheon meeting on the campus, during the university's 5th annual medical alumni reunion.

The two physicians were cited for "outstanding professional attainment and . . . distinguished service to mankind through an unswerving devotion to the highest ideals in the practice of the art and science of medicine."

Some 325 graduates of the medical school attended the day-long reunion events.

Dr. Beatty, a professor emeritus of otolaryngology in the College of Medicine, was a member of the medical teaching staff for 35 years before his retirement in 1951.

Dr. Polley, born and reared in Columbus, earned his medical degree from Ohio State in 1938 and a master's degree in medicine from the University of Minnesota. He has been associated with the Minnesota Graduate School's medical faculty at the Mayo Foundation for 12 years. He took part in the original clinical investigations of cortisone and ACTH in rheumatoid arthritis.

Shoe Fitting Fluoroscopes . . .

Use of These Devices Prohibited in Ohio by Department of Health Acting Under Authority of Legislative Act, Except by Physician or Chiropodist

THE use of fluoroscopes for shoe fitting purposes, other than by a physician or a chiropodist, was prohibited in Ohio as of May 1, 1958.

This action was taken by the Public Health Council of the Ohio Department of Health at a public hearing in Columbus, April 12, through the adoption of Regulations 425 and 426 reading as follows:

"**Regulation 425.** On and after May 1, 1958, the use of fluoroscopes for shoe fitting purposes, other than by a physician or a chiropodist, is hereby prohibited.

"**Regulation 426.** The sale, lease, loan, donation or other transfer of shoe fitting fluoroscope equipment, used prior to the effective date of this regulation, except to physicians, chiropodists, hospitals, medical and dental schools, accredited colleges and universities, and manufacturers, wholesalers and retailers of such equipment is hereby prohibited."

Authority for the issuance of these regulations came from the enactment of Amended House Bill 294 by the 102nd Ohio General Assembly last year. The bill was introduced by Hon. A. C. Lancione who represents Belmont County in the Ohio General Assembly. In explaining why passage of the bill was necessary to protect the health of the public, Mr. Lancione used authoritative material which had been secured for him by the OSMA headquarters staff from the American Medical Association and from medical societies in several states where similar legislation has been enacted.

Supporting testimony was given by Dr. Ralph E. Dwork, State Director of Health, who pointed out the potential danger of radiation from shoe fitting x-ray machines. He estimated that there were currently as many as 800 fluoroscopes in use in Ohio shoe stores.

A member of the OSMA headquarters staff testified at hearings on the bill before the House Committee on Health and the Senate Committee on Education and Health. He told the legislators that the bill had the endorsement of The Council of the Association, and urged that it be recommended for passage. Favorably acted upon by these committees, the measure passed the House by a vote of 95-1. The Senate vote was 29-0. Gov. C. William O'Neill signed it on June 10, 1957.

As amended by AHB 294, Section 3701.13 of the Revised Code now reads as follows: (amendment in italics)

"Sec. 3701.13. The department of health shall have supervision of all matters relating to the preservation of the life and health of the people and have supreme authority in matters of quarantine, which it may declare and enforce, when none exists, and modify, relax, or abolish, when it has been established. It may make special or standing orders or regulations *for preventing the use of fluoroscopes for non-medical purposes which emit doses of radiation likely to be harmful to any person,* for preventing the spread of contagious or infectious diseases, for governing the receipt and conveyance of remains of deceased persons, and for such other sanitary matters as are best controlled by a general rule. It may make and enforce orders in local matters when an emergency exists, or when the board of health of a general or city health district has negleted or refused to act with sufficient promptness or efficiency, or when such board has not been established as provided by sections 3709.02, 3709.03, 3709.05, 3709.06, 3709.11, 3709.12, and 3709.14 of the Revised Code. In such cases the necessary expense incurred shall be paid by the general health district or city for which the services are rendered."

Activities of The Editor

Dr. Jonathan Forman, Columbus, Editor of *The Journal,* participated in an instruction course of the American College of Allergists in Atlantic City the week of April 20, conducting a demonstration on history taking of allergic patients. He presided also at a half-day program and later conducted a workshop on medical writing.

On May 7 he conducted a workshop on medical writing at Wayne University, Detroit, on the Alumni Day of the College of Medicine.

May 25-27 were the dates for a program arranged by him on ecology of man and agriculture at Malabar Farm near Mansfield. This was one of a series of programs being arranged there under his direction.

Health Care of the Aged . . .

Joint Council Representing Major Organizations Interested in Subject, Size Up the Situation and Approach Problems with a Three-Sided Attack

BETTER health care for the nation's 14- to 15-million aged is the goal of a comprehensive program announced by the Joint Council to Improve the Health Care of the Aged, the formation of which was described in the May issue of *The Journal.*

The council's attack on the more knotty problems of health care for the aged is designed to: (1) increase opportunities for older people to obtain voluntary health insurance coverage, (2) expand health care facilities tailored to the needs of the aged regardless of economic status, and (3) develop more community health services for the aged.

The program will be implemented through the active and aggressive leadership of the council's four sponsoring organizations—the American Dental Association, American Hospital Association, American Medical Association, and the American Nursing Home Association.

"Member organizations of the Joint Council," said Dr. Edwin L. Crosby, director of the American Hospital Association and interim secretary of the council, "have already undertaken studies and work projects aimed at improving the health care of the aged." Among the many activities which these groups have undertaken or in which they have cooperated he listed the following:

What Is Being Done

(1) The American Hospital Association, in cooperation with the Public Health Service, is conducting a conference on the care of patients with long-term illnesses.

(2) An American Medical Association committee is working with the American Nursing Home Association in preparing upgraded standards for nursing homes which will result in improved nursing home care for the aged.

(3) A National Conference on Homemaker Services is being arranged under the joint auspices of the Department of Health, Education and Welfare and twenty-six national voluntary organizations including the American Medical Association. This project is aimed at reducing the financial expense of disabling illness among the elderly by performing the necessary household tasks to enable them to remain at home among their family and friends, with qualified nursing and medical attendance in the home.

(4) Six regional conferences have been held under the auspices of the American Medical Association to help doctors cope with problems of the aged, and a national conference will be held in September.

Practical Application

The Joint Council will appraise the success of these programs and seek their application through united effort.

"The long-range aim of the council is better health for all the aged," Dr. Crosby asserted. "This can be achieved by helping everyone to prepare throughout his life for the later years. Our more immediate concern is better care for the aged who are chronically ill, and better ways to meet the financial and social problems that accompany such illness."

He said, "The Joint Council has found that sufficient up-to-date information concerning the problem is not available. A series of research projects has been launched to pinpoint the problems that require the most urgent attention."

"In addition," he continued, "the Joint Council will seek the expansion and improvement of health care facilities by encouraging legislative action to accelerate construction and remodeling of hospital and nursing home facilities for the aging.

To better meet the problems of the financial expense of prolonged hospitalization for chronic illnesses, the Joint Council is working with the voluntary health insurance industry, including Blue Cross and Blue Shield prepayment plans, to accelerate and broaden their programs that have already resulted in some degree of coverage of 6 million persons over 65 in a few short years.

The Joint Council has emphasized the need for state and local governments to assume their proper responsibility to indigent patients, by providing realistic financial support for medical, dental, hospital, and nursing home care for the aging who are unable to pay.

Dr. Crosby said, "The broad health care plan of the Joint Council includes an educational program at the national, state and local levels. Its purpose is to make all citizens aware of the growing health problems of the aging and what can be done by the individual to assist in this field. The council plans to enlist the continued aid and support of America's voluntary community organizations."



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Medicare Rulings . . .

Central Office Issues Bulletin Outlining Circumstances Under Which The Government Will or Will Not Pay for Care in Controversial Cases

DELINEATION of the responsibility of the Government for payment of claims covering care of controversial conditions and procedures which may or may not be considered as belonging in the general classification of "elective medical and surgical treatment" is found in a bulletin issued May 5 by the Office of Dependents' Medical Care, Washington, over the signature of Maj. Gen. Paul I. Robinson, director.

The content of this bulletin is of vital importance to the operation of the program and to all physicians handling Medicare cases. Therefore, all physicians should read the following excerpts from the bulletin carefully:

The following specific conditions and procedures are examples which are admittedly not all-inclusive; however, they are representative of the vast majority of claims and inquiries concerning questionably authorized care referred to the Office for Dependents' Medical Care. Treatment of chronic conditions is authorized only if acute exacerbations or acute complications exist; or if surgical or other treatment procedures are expected to result in functional improvement. Comments for each condition or procedure indicate whether care rendered *is* or *is not* payable under Medicare. **Unless specific exception is made in the comment, the condition or procedure must have required hospitalization for proper treatment.**

a. **Ears:** Large, flapping, elephant-like or otherwise deformed or absent. Reconstruction and/or revisions of external ear only are elective and not payable under Medicare. Surgery performed for, and based solely on, psychological reason is not allowable. Necessary procedures for the restoration of hearing, to include reconstruction of the middle and/or inner ear and/or such part of the external ear as may be required for restoration of hearing, is allowable under the program.

b. **Eyes:** Surgery for glaucoma, cataracts, strabimus (squint) or other conditions to aid or improve the vision of the affected eye(s) is allowable. The cost of prosthetic devices or orthoptic exercises is not allowable; neither is surgery performed solely for improvement of appearance.

c. **Harelip and/or Cleft Palate:** Surgery for the initial repair, including surgery considered an integral continuing part of the initial repair, is allowable. Subsequent procedures, employed for the improvement of appearance only, are not allowable.

d. **Rhinoplasties:** When performed solely for improvement of appearance, Rhinoplasties are not allowable.

e. **Congenital Defects—Skeletal:** Allowable when prescribed treatment is required to be performed in the hospital on an "inpatient" basis. Where it is customary for plaster casts to be applied on an outpatient basis and hospitalization is not required for proper treatment, such procedures are not allowable. Examples:

(1) Clubfoot—uni- or bi-lateral.

(2) Congenital dislocation of hips—uni- or bi-lateral.

(3) Other types of congenital skeletal defects requiring casts or other treatments.

f. **Cerebral Palsy or Poliomyelitis (residuals):** Surgical procedures such as arthrodesis, osteotomies, or tendon transplants required for the improvement or restoration of function are allowable only for the pertinent period of hospitalization specifically related to the surgical procedure but not for medical care related to the basic condition. Consequently, follow-up treatments for rehabilitation of the basic condition are not authorized; neither are payments for wheel chairs, crutches, braces, and prosthetic devices, or other adjunctive surgical support items authorized.

g. **Central Nervous System—Congenital Defects:** Surgical correction of evaginations of the contents of the vertebral column, as well as hydrocephalus and other congenital abnormalities, is allowable.

h. **Supernumerary Digits and Syndactylism:** Surgery required to improve function of the involved extremity(ies) is allowable. When performed solely at the request of the patient and/or sponsor in the absence of functional impairment, payment is not authorized.

i. **Scars:** Except as provided herein, surgery or other medical treatment on well-healed scars is not authorized. Treatment of scars that are ulcerated, or show clinical evidence of malignancy, or cause contractures which impair anatomical function is allowable. Reconstructive surgery incident to an injury is allowable as a part of the continuing

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total treatment of that injury and may be performed on an outpatient basis, if appropriate.

j. **Removal of Plantar Warts, Other Warts (Verrucae), Sebaceous Cysts, Condylomata, Moles, Pigmented Nevi, Hemangiomata and/or Telangiectatic Lesions:** Authorized only if they are bleeding, ulcerated, painful, or show clinical evidence of malignancy, or if the size and location produces functional impairment.

k. **Removal of Tattoos:** Not allowable.

l. **Tubal Ligation or Other Sterilization Procedures:** Authorized for payment only when, in the opinion of the charge physician and consulting physician(s), the procedure is a necessary requirement in the proper medical management of an otherwise unrelated medical or surgical condition for which treatment is authorized under the program. Multiparity and/or the socio-economic status of the patient are not bona fide reasons for payment of sterilization procedures under the Dependents' Medical Care Program.

m. **Mammoplasty:** Surgical procedures on the breast(s) for the purpose of effecting symmetry or alteration of size are not authorized except when severe pain and/or marked disability is present.

n. **Tests and Procedures for Sterility or Fertility Influences:** Are allowable only when clinical indication of associated pathological condition causing impairment is present. Tests are not allowable when performed solely at the request or desire of the patient (sponsor).

o. **Tests for Pregnancy:** Allowable only if the patient is, in fact, pregnant; or when considered necessary for the proper conduct of maternity or postpartum care, regardless of the test results (i. e. hydatidiform mole). These tests are not allowable when requested by the patient and are found to be negative. When authorized, these tests may be performed on an outpatient basis as other antepartum or postpartum care.

Exceptional Children

p. **Services for "Exceptional" Children:** Not authorized. Examples include:

(1) Cerebral palsy treatment including surgical procedures unless they qualify under paragraph 2f, above.

(2) Speech and/or hearing therapy, or remedial reading.

(3) Psychological testing.

(4) Child guidance therapy.

Note: It is emphasized that a **basic requirement for allowability** of claims for payment for conditions or procedures identified in subparagraphs **a** through **p,** above, **is the necessity of hospitalization for proper accomplishment.** Exceptions for injury and maternity cases have been specifically identified in subparagraphs **i** and **o,** above.

3. For all conditions outlined above and other similar or questionable cases, physicians and hospitals are urged to attach a statement by the attending physician to the Medicare Claim Form (DA Form 1863) at the time it is submitted to the Fiscal Administrator. Provided the information is adequate to establish the authorization for care and provided the charges are within the applicable Schedule of Allowances, the fiscal administrator may process the claim for payment without reference to this office.

4. For all conditions outlined above and other similar or questionable cases, physicians are particularly urged to predetermine its eligibility for payment under the Dependents' Medical Care Program. A frank discussion of the entire problem with the patient and/or sponsor prior to the initiation of treatment is felt to be extremely advisable. **Physicians, hospitals, and patients must realize that the government is not liable for payment of unauthorized care.** Prior to acceptance of the patient for treatment, any questionable case should be referred to the local fiscal administrator for assistance in determining eligibility. In the exercise of this function, the fiscal administrator may seek advice from the office for Dependents' Medical Care. All pertinent facts must be submitted to the Office for Dependents' Medical Care to enable an expeditious and intelligent decision.

New Members on Advisory Committee To Selective Service Named

President Eisenhower has appointed three additional members of the National Advisory Committee to Selective Service on the Selection of Physicians, Dentists and Allied Specialists to replace members who have resigned.

The new Committee members are:

Leo H. Bartemeier, M.D., Baltimore, Maryland; medical director, Seton Institute, Baltimore, and chairman of the Council of Mental Health of the American Medical Association.

John Z. Bowers, M.D., Madison, Wisconsin; dean, University of Wisconsin School of Medicine; formerly dean of the Medical School, University of Utah.

George M. Fister, M.D., Ogden, Utah, private practice; regent, University of Utah; member, Board of Trustees of the AMA.

Other members of the Committee are: Dr. Elmer Hess, chairman, Dr. Mary Louise Gloechner, Dr. William B. Walsh, Dr. George Otis Whitecotton, Dr. Franklin Yoder, Harold W. Oppice, D.D.S., and Frances Graff, R.N.

Buckeye News Notes

Xenia—Dr. R. David Warner has been elected president of the Xenia Rotary Club and will assume that office July 1.

Doylestown—For 25 years of service to his community, both as a physician and a civic leader, Dr. Byron Eugene Neiswander was honored at a special Lion's Club meeting and was the subject for a feature article in the *Akron Beacon-Journal.*

East Liverpool—Cancer Crusade workers from eight counties, meeting in Warren, heard an address on "Importance of Early Diagnosis in Cancer," by Dr. John A. Fraser of East Liverpool.

Dayton—The Ohio Junior Chamber of Commerce has selected Dr. Kenneth D. Arn as one of the five outstanding young men in Ohio, for which he has received a 1957 distinguished service award.

Cleveland—After 23 years of voluntary service, Dr. Victor F. Woldman has retired as chief of the medical staff at Mary B. Talbert Home and Hospital. He was presented a bronze plaque for his service.

Washington Court House—Heart disease and cardiology was the topic discussed by Dr. Robert Woodmansee when he addressed a meeting of the Fayette County Professional Nurses Association.

Ashley—Waldo Town and Country Mothers' Club heard Dr. Mary Kuhn speak on "When and How to Call the Doctor."

Niles—Drs. John F. McGreevey, Richard W. Aubrey and John A. Grima, with Dr. James W. Loney as moderator, comprised a panel which discussed "A Doctor's View of Cancer," as a feature of the Niles Cancer Crusade kickoff dinner.

Ashtabula—The lead editorial in the April 11 issue of the *Star-Beacon* was an eulogy to the late Dr. Clarence E. Case, who served the area 58 years.

Mentor—Members of the Mentor Preschool Parent-Teachers Association heard a talk on "Family Immunization Program," given by Dr. H. A. Killian.

Conneaut—Dr. R. M. Bartlett of Akron, who also is moderator of the Ohio Conference of Congregational Christian Churches, was principal speaker at the Conneaut Community Men's Brotherhood Banquet.

Marion—Recent discoveries in radioactivity and its uses in medicine was the topic chosen by Dr. Charles W. Wilson in an address before the local Kiwanis Club.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

April 1, 1958—Robert C. Ackles, Akron, Cornell University; Marshall I. Alperin, Cincinnati, Tulane University;

Peter S. Battaglia, Euclid, Univ. of Buffalo; William J. Beckmeyer, Jr., Cincinnati, Georgetown Univ.; Antone L. Bertoglio, Akron, Marquette Univ.; Willis T. Blair, Cleveland, Jefferson Medical College; Milton A. Boyd, Cambridge, George Washington Univ.; John F. Brunner, Toledo, St. Louis Univ.;

Harold E. Ciccarelli, East Liverpool, Univ. of Pittsburgh; Kenneth C. L. Clark, Cincinnati, Medical College of Virginia; David H. Clements, Jr., Cleveland, Temple University; Milton H. Clifford, Cincinnati, Harvard Medical School; John S. Collis, Jr., Cleveland, Univ. of Louisville; Rufus E. Craven, Cincinnati, Univ. of Tennessee; Samuel Gross, Shaker Heights, Univ. of Rochester; Donald A. Cryan, Toledo, St. Louis Univ.;

Forest D. Daugherty, Dayton, Indiana University; Curtis J. Fisher, Youngstown, Hahnemann Medical College; John D. Franz, Dayton, Indiana University; Charles H. Frie, Toledo, Indiana University; Avrum I. Froimson, Cleveland, Tulane University;

Lucito G. Gamboa, Youngstown, Univ. of Santo Tomas, Philippines; Louis J. Goetz, Dayton, St. Louis Univ.; Kingsbury G. Heiple, Cleveland Heights, Univ. of Chicago; John C. Herrman, Cleveland, Jefferson Medical College; George G. Hibbs, Cincinnati, Northwestern Univ.; Robert W. Hopkins, Cleveland, Harvard Medical School;

John M. Kearney, Marion, Univ. of Pennsylvania; Arthur F. Krieg, Cleveland, Tufts College; Ching Po Li, Dayton, Univ. of Utah; Fernando Lim, Cleveland, Univ. of the Philippines;

Julius L. Markowitz, Cleveland, Jefferson Medical College; Ligita G. B. Moettus, Univ. of Minnesota; Gilbert C. Morrison, Cincinnati, Tulane Univ.; John H. Muehlstein, Dayton, Northwestern University;

Herbert M. Nakata, Cleveland, St. Louis Univ.; Martha J. D. Nelson, Akron, Univ. of Pittsburgh; Eugene C. Ney, Bellaire, Univ. of Kansas; Jacob W. Old, Jr., Columbus, Washington Univ.; Wil-

(Continued on Next Page)

liam J. Paule, Lakewood, Yale University; Warren H. Pearse, Gallipolis, Northwestern Univ.;

Brady F. Randolph, Jr., Cleveland, Northwestern Univ.; Norman O. Reese, Cleveland, Univ. of Rochester; Herman Reiner, Akron, Univ. of Geneva, Switzerland; Charles W. Reynolds, Akron, Temple Univ.; Robert E. Roberts, Toledo, Indiana University;

William L. Santen, Cincinnati, St. Louis Univ.; Manuel Sarmina, Findlay, National Autonomous Univ. of Mexico; Joseph M. Schuster, Jr., Cleveland, St. Louis Univ.; Amos V. Smith, Jr., Jefferson Medical College; Robert A. Smith, Toledo, Univ. of Buffalo; Robert C. Smith, Cleveland, Univ. of Pittsburgh; William J. Staab, Jr., Cleveland, St. Louis Univ.;

Carolyn F. Taylor, Cleveland, Univ. of Oregon; Dominic A. Thomas, Piqua, Royal Univ. of Parma, Italy; Emma J. S. Yoho, Brecksville, Medical College of Virginia.

Dr. Harold Cashman, director of the Southeast Ohio Tuberculosis Hospital, Nelsonville, has resigned to accept a post as health commissioner of Belmont and Harrison Counties.

AMA Sponsors San Francisco Civil Defense Program

The American Medical Association, through its Council on National Defense, is sponsoring its Sixth Annual National Civil Defense Conference on Saturday, June 21, at the Sheraton-Palace in San Francisco. That date is the Saturday immediately preceeding the AMA Annual Session in the same city.

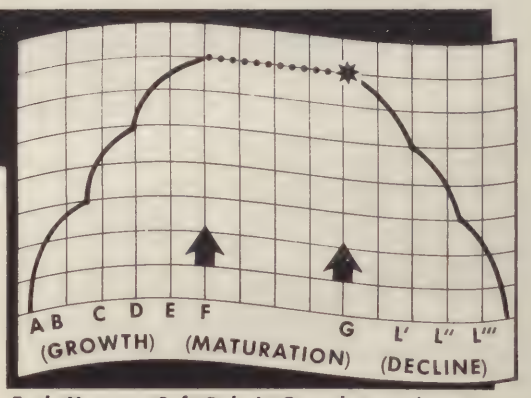
Dr. Hein Is Editor of New Education Yearbook

Fred V. Hein, Ph.D., of the AMA Bureau of Health Education, served as the editor of the new, completely rewritten edition of the book *Fit to Teach*, an important publication from the standpoint of health and medical care in the field of education.

Fit to Teach is the yearbook of the American Association for Physical Education and Recreation and was produced in cooperation with several other educational groups. A number of other staff members of the AMA Bureau of Health Education as well as many physicians served either as contributors or as consultants.

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Complaints of symptoms such as muscular pain, fatigue, irritability, and poor appetite in the patient over 40 may be the first indications of three major stress factors in the aging process: (1) Gonadal Hormonal Imbalance, (2) Nutritional Inadequacy and (3) Emotional Instability. GERITAG is especially formulated to guard against premature damage and to delay the degenerative process.

Rx GERITAG in preventive geriatrics.

Each Magenta Soft Gelatin Capsule contains:

Methyltestosterone	2 mg.	Thiamine Hcl.	2 mg.
Ethinyl Estradiol	0.01 mg.	Riboflavin	2 mg.
Ferrous Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niacinamide	20 mg.
Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
Vitamin D	400 I.U.	Methionine	20 mg.
Vitamin E	1 I.U.	Inositol	20 mg.
Cal. Pantothenate	3 mg.		

Also available as injectable.

*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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In Memoriam . . .

Robert M. Blair, M. D., Lebanon; Ohio State University College of Medicine, 1913; aged 70; died March 31; former member of the Ohio State Medical Association. Dr. Blair served all of his professional career in the Lebanon area, where for a number of years he operated the Blair Hospital with his brother, the late Dr. Ed Blair. Surviving are his widow and a son.

Donald S. Booth, M. D., Toledo; University of Michigan Medical School, 1928; aged 55; died April 30; member of the Ohio State Medical Association and the American Medical Association. A resident of Toledo for most of his life, Dr. Booth returned there to practice after his medical training. A sailing enthusiast, he was commodore of the Ohio-Indiana District, Lightning Fleet Association. He was a member also of the Toledo Lightning Class Association, the Toledo Yacht Club, the Masonic Lodge and Phi Chi fraternity. Surviving are his widow, two sons, two daughters, a sister and a brother.

Daniel W. Brickley, Sr., M. D., Marion; Ohio Medical University, Columbus, 1904; aged 81; died April 15; member of the Ohio State Medical Association and recipient of its 50-Year Award; member of the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology. Dr. Brickley began his practice in Galion and moved to Marion in 1913. He was a past-president of the Marion County Academy of Medicine and was active in several Masonic bodies. Surviving are his widow, two sons, one of whom is Dr. Daniel W. Brickley, Jr.; also a brother and a sister.

Elmer E. Carleton, M. D., Columbus; Starling Medical College, Columbus, 1895; aged 93; died April 4; former member of the Ohio State Medical Association, and recipient of the OSMA 50-Year Award. Dr. Carleton served most of his professional career in Columbus, and retired from active practice only five years ago. He was a deacon in the Baptist Church. A brother survives.

Clarence E. Case, M. D., Ashtabula; Western Reserve University School of Medicine, 1895; aged 87; died April 9; member of the Ohio State Medical Association and recipient of the OSMA 50-

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Dilcoron TRADEMARK

ORAL (tablet swallowed whole)
for dependable prophylaxis
SUBLINGUAL-ORAL
for immediate and sustained relief
of ANGINA PECTORIS



NITROGLYCERIN—
0.4 mg. (1/150-grain)—acts quickly

CITRUS "FLAVOR-TIMER"—
signals patient when to swallow

PENTAERYTHRITOL TETRANITRATE—
15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet.
Average prophylactic dose:
1 tablet four times daily.
Therapeutic dose:
1 tablet held under the tongue until citrus flavor disappears, then swallowed.

Bottles of 100.

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Year Award; member of the American Medical Association; Fellow of the American College of Surgeons. Dr. Case had a long and eventful professional career in and around Ashtabula. He and his father, the late Dr. Freeman D. Case, were instrumental in building of the Ashtabula General Hospital. In 1950 he was honored for 45 years of service to the New York Central Railroad as surgeon. He was a charter member and first president of the local Rotary Club; a member of the Masonic Lodge and the Elks Lodge. His widow survives.

Frank R. Clemson, M. D., Thornville; Starling Medical College, Columbus, 1898; aged 82; died April 18; member of the Ohio State Medical Association and recipient of the Association's 50-Year Award. Dr. Clemson practiced some 60 years in the Thornville area with time out only for service during World War I in the Army Medical Corps. He was a member of the Methodist Church, several Masonic bodies and the American Legion. Survivors include a daughter, three grandchildren, a brother and a sister.

James R. Echelbarger, M. D., Ottawa; Starling Medical College, Columbus, 1906; aged 83; died April 8; recent member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Echelbarger had been a practicing physician in and around Ottawa since 1923. He previously practiced in Piqua. He was a member and past-master of the Masonic Lodge, past noble grand of the Odd Fellows and a member of the Methodist Church. Surviving are his widow, a daughter, a sister and two brothers.

Frank P. Geraci, M. D., Cleveland; Western Reserve University School of Medicine, 1917; aged 66; died May 6; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Geraci served all of his professional career in the Cleveland area with the exception of time served in the Army Medical Corps during World War I. A founding member of his local Catholic Church, he was active in its men's organizations. He also was a member of Phi Chi and Alpha Phi Delta. Surviving are his widow, four daughters, two brothers and two sisters.

George O. Gill, M. D., Elyria; University of Illinois College of Medicine, 1896; aged 92; died April 1; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award; Fellow of the American College of Surgeons and diplomate of the American Board of Ophthalmology. A physician of long standing in the Elyria area, Dr. Gill was chief of staff of the Elyria Memorial Hospital for many years. During early years, he took time out to study in London, Vienna and Berlin. A member of the Congregational Church and the Masonic Lodge, he is survived by two daughters.

John F. Heath, M. D., Dayton; Eclectic Medical College, Cincinnati, 1918; aged 72; died April 3; former member of the Ohio State Medical Association. Dr. Heath was a practicing physician in the Dayton area for many years. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow and two sisters.

Charles D. Hauser, M. D., Youngstown; University of Buffalo School of Medicine, 1896; aged 82; died April 7; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A physician of long standing in Youngstown, Dr. Hauser had been honored with the 50-Year Award of the OSMA. He was first elected to the American College of Surgeons in 1915. Dr. Hauser was a veteran of World War I, having served as captain with the Army Medical Corps. He was a member of the Elks Club and the Youngstown Club. Surviving are his widow, a daughter and two sisters.

Hugh H. Hengstenberg, M. D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 57; died March 27 as the result of a traffic accident; member of the Ohio State Medical Association, the American Medical Association and the Industrial Medical Association. A practicing physician in Cincinnati for about 33 years, Dr. Hengstenberg was physician for the Cincinnati Gas & Electric Company for 30 years. He was a member of the Indian Hill Church, the Cuvier Press Club and the Queen City Club. Surviving are his widow, a daughter, a son and his mother.

Marvin Phillip Jaffe, M. D., Cleveland; Ohio State University College of Medicine, 1956; aged 27; died April 17 in a traffic accident. Dr. Jaffe was taking residency training at Billings Hospital in Chicago and was visiting in Cleveland when the accident occurred. He is survived by his parents and two brothers.

Samuel A. Laughlin, M. D., Aberdeen; Medical College of Ohio, Cincinnati, 1897; aged 83; died April 16; former member of the Ohio State Medical Association, and recipient of the OSMA 50-Year Award. Dr. Laughlin was a practicing physician in Brown County for virtually all of his professional career.

William E. Leever, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 83; died



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Neomycin sulfate (Equal to neomycin base, 210 mg.)	300 mg.
Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Dihydroxyaluminum aminoacetate	0.25 Gm.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

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April 4; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Leever practiced in the Mt. Auburn area of Cincinnati from 1931 until his retirement in 1949. He had previously practiced in Owensville, Clermont County. Affiliations included memberships in the Masonic Lodge and the Odd Fellows. Surviving are his widow, a daughter, three sons and two sisters.

David R. Mathie, M. D., Newton Falls; University of Michigan Medical School, 1931; aged 55; died April 24; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Mathie practiced medicine in and around Newton Falls for about 25 years and was Trumbull County health commissioner since the first of the year. He was a member of the board of the Methodist Church, a member of the Kiwanis Club, several Masonic bodies and the Trumbull Country Club. Surviving are his widow, a daughter and a son.

Orrin Clark McDowell, M. D., Orrville; Ohio State University College of Medicine, 1917; aged 64; died March 28; member of the Ohio State Medical Association and the American Medical Association. Long a resident of Orrville, Dr. McDowell returned there to practice in 1920 after service in the Army Medical Corps during World War I and a short stay in Akron after the war. In addition to his practice he participated in numerous civic activities. For many years he was physician to the local high school football team; he helped organize and was first president of the Exchange Club; was a 32nd Degree Mason and a member of the American Legion. Survivors include his widow, a brother and a sister.

William R. Moore, Jr., M. D., Cleveland; Indiana University School of Medicine, 1952; aged 32; died May 4 in an airplane accident; member of the Ohio State Medical Association and the American Medical Association. Dr. Moore was a practicing physician in Cleveland. He was a veteran of World War II. Surviving are a son and his parents, Dr. and Mrs. William Moore, also of Cleveland.

Joseph A. Neuberger, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1908; aged 81; died April 21; former member of the Ohio State Medical Association. Dr. Neuberger was a practicing physician in Cleveland for all of his professional career. Until 1920 he practiced in association with his wife, who also is a physician. He was a member of several Masonic bodies including the Consistory and Shrine. His widow, Dr. Bernice L. Neuberger, survives.

James W. Papez, M. D., Columbus; University of Minnesota Medical School, 1911; aged 74; died April 13; member of the Ohio State Medical Association, the American Medical Association and the Association for Research in Nervous and Mental Diseases. Dr. Papez had been director of the laboratory for the Columbus State Hospital since 1951. He came to Ohio from Cornell University Medical School where he was professor of anatomy. Prior to 1920 he held appointments on the faculties of Atlanta College of Physicians and Surgeons and Emory University Medical School. Surviving are his widow, two sons, a daughter, two brothers and two sisters.

James B. Penrose, M. D., Marietta; University of Pennsylvania School of Medicine, 1906; aged 76; died April 11; member of the Ohio State Medical Association and recipient of the Association's 50-Year Award; past-president of the Washington County Medical Society. Dr. Penrose practiced medicine in Marietta for 51 years. During World War I he served with the Army Medical Corps and during World War II was in charge of the Marietta medical division of Civil Defense. He was a 32nd degree Mason, a member of the Episcopal Church, Delta Upsilon and Nu Sigma Nu. Surviving are his widow, two sons and a brother.

Otto V. Pertik, M. D., Dayton; University of Budapest, Hungary, 1916; aged 64; died April 23. Dr. Pertik had been a member of the medical staff at the Dayton Veterans Administration center for about a year. He came to this country about seven years ago. Surviving are his widow, a daughter and two sons; also a sister and two brothers in Hungary.

Franklin A. Rice, M. D., Niles, Mich.; University of Wooster, Medical Department, Cleveland, 1909; aged 72; died April 9; former member of the Ohio State Medical Association; Fellow of the American College of Surgeons. Dr. Rice was a practicing physician in Cleveland for many years





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DARVON (Dextro Propoxyphene Hydrochloride, Lilly) is equally as potent as codeine yet is much better tolerated. Side-effects, such as nausea or constipation, are minimal. You will find 'Darvon' helpful in any condition associated with pain. The usual adult dose is 32 mg. every four hours or 65 mg. every six hours as needed. Available in 32 and 65-mg. pulvules.

DARVON COMPOUND (Dextro Propoxyphene and Acetylsalicylic Acid Compound, Lilly) combines the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound'* with the analgesic properties of 'Darvon.' Thus, it is useful in relieving pain associated with recurrent or chronic disease, such as neuralgia, neuritis, or arthritis, as well as acute pain of traumatic origin. The usual adult dose is 1 or 2 pulvules every six hours as needed.

Each Pulvule 'Darvon Compound' provides:

'Darvon'	*32 mg.*
Acetophenetidin	*162 mg.*
'A.S.A.' (Acetylsalicylic Acid, Lilly)	*227 mg.*
Caffeine	*32.4 mg.*

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before his retirement in 1947. A veteran of the Army Medical Corps of both World Wars, he held the rank of colonel. Affiliations included memberships in the Cleveland Library Association, several Masonic bodies, and the American Legion. Surviving are his widow; a son, Dr. Franklin G. Rice, of Niles, Mich., and two brothers.

Emma L. Templin, M. D., Hillsboro; Woman's Medical College, Cincinnati, 1891; aged 100; died April 17. Dr. Templin was a former practicing physician and before the turn of the century was a medical missionary in India for the Presbyterian Church. She had been a resident of Hillsboro for 35 years.

William Clarence Terwilliger, M. D., Akron; Chicago College of Medicine and Surgery, 1915; aged 71; died April 11; former member of the Ohio State Medical Association. Dr. Terwilliger had been a practicing physician for 43 years, 38 of them in Akron. Survivors include his widow, two daughters, three brothers and a sister.

Harry J. Wittenberg, M. D., Cincinnati; Cincinnati College of Medicine and Surgery, 1901; aged 76; died April 4; former member of the Ohio State Medical Association, and recipient of the OSMA 50-Year Award. Dr. Wittenberg practiced medicine for many years in Cincinnati and formerly was medical director of the Cincinnati Health Center, and at one time was health commissioner of Norwood. He is survived by a widow, a son and three sisters.

Ohio State Rates "Grand Rounds" TV Program in First Place

"Grand Rounds," the Upjohn Company's closed-circuit medical programs, won first award for a network educational series in a national competition sponsored by the Ohio State University. The citation was issued by the Institute for Education by Radio-Television of the University.

The next "Grand Rounds" will be telecast on the evening of June 25 from San Francisco as part of the AMA meeting there.

The Three Ohio Medical Schools Receive Education Grants

Ohio's three medical schools each received part of the $3,178,825 worth of grants from the National Fund of Medical Education.

Included in the 82 schools receiving grants are Ohio State University College of Medicine, $51,-855; Western Reserve University School of Medicine, $35,930; and the University of Cincinnati College of Medicine, $37,295.







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why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

why combine the two? *For greater therapeutic success:* In clinical trials, CARTRAX was demonstrably superior to previous therapy, including PETN alone. Specifically, 87% of angina patients did better. They were shown to suffer fewer attacks . . . require less nitroglycerin . . . have increased tolerance to physical effort . . . and be freed of cardiac fixation.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

CLERMONT

Dr. Albert H. DeGarmo, Cincinnati, spoke on the subject, "Pediatric Problems," at the April 23 meeting of the Clermont County Medical Society. The program was held at the DX Ranch, with Dr. Frederick P. Baurichter as host.

HAMILTON

"Space Medicine" was the topic for the May 6 meeting of the Academy of Medicine of Cincinnati in the College of Medicine Auditorium. The speaker was Major General Dan C. Ogle, Surgeon General, U. S. Air Force, Washington, D. C. Dinner preceded the program.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

The Clark County Medical Society voted April 21 to back a city proposal to increase the city income tax from six-tenths of a per cent to one per cent.

Springfield city officials have maintained additional money is needed to carry out a long-range program of improvements.

By backing the proposal, the Clark County Medical Society joined some 35 other organizations here in favor of the increase.

The vote to back the tax proposal came at the general meeting of the society in Hotel Shawnee, Springfield.

Dr. Ray M. Turner, a society delegate to the state meeting, reported on the Cincinnati session.

Guest speaker at the meeting was Dr. Geo. J. Hamwi, of Ohio State University's department of endocrinology. Dr. Hamwi's topic was "Present Concepts of Adrenal Disorders and Adrenal Psychology."

The *Springfield News-Sun* cooperated with the Clark County Medical Society for Medical Education Week by publishing an illustrated article on the Society's call service.—Tom Duross.

MIAMI

A joint meeting of the Miami and Shelby County Medical Societies was held on April 3 at the Piqua Country Club for luncheon and a program. Dr. Drew J. Arnold, assistant professor of surgery at Ohio State University, discussed the subject "Regional Ileitis."

Another joint meeting of the Miami and Shelby Societies was held on May 1 with members of the Auxiliaries. After a social period and dinner, an entertaining and instructive program was presented by Ted Bumiller, Cincinnati architect and world traveler who showed his color-sound film, "By Jeep Around the World." Approximately 75 members and guests were present.

(See separate article on Page 803 in this issue, for special honors to Dr. George A. Woodhouse.)

MONTGOMERY

Dr. Robert E. Zipf, Montgomery County coroner and director of the research department at Miami Valley Hospital, addressed a joint meeting on April 16 of the Section on General Practice of the Montgomery County Medical Society and the local chapter of the Academy of General Practice. He spoke on "New Advances in Isotopic Medicine" and "Problems of the Coroner's Office."

A joint meeting of the Montgomery County Medical Society and the Dayton Surgical Society was held on April 29. Guest speaker was Dr. Orvar Swenson, chief surgeon at the Boston Floating Hospital for Infants and Children, and clinical professor of surgery at Tufts Medical School. He discussed "Abdominal Pain in Childhood."

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Dr. Robert C. Horn, director of the laboratory for the Ford Hospital in Detroit, spoke at the dinner meeting of the Academy of Medicine of Lima and Allen County on April 15. His subject was "Cancer of the Gastrointestinal Tract." The meeting was held at the Shawnee Country Club.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

LUCAS

The Academy of Medicine of Toledo and Lucas County listed the following programs on its schedule of events for April and May:

General Section, April 11 — Presentation of papers by interns and residents of Toledo Hospitals. Awards given by the Medical Advancement Trust of Maumee Valley Hospital.

Surgical Section, April 25—"Carcinoma of the Esophagus," Dr. Robert A. Mustar, University of Toronto.

May 2, General Practice Section — "Hearing Problems in Children," a discussion by a panel of physicians and lay people.

May 7, Presentation of Surgical Papers by Interns and Residents of Toledo Hospitals. Presentation of awards by the Toledo Chapter, American College of Surgeons.

May 16, Medical Section—"Current Develop-

ments in Therapy of Certain Hematological Problems," Dr. Henry E. Wilson, professor of Medicine and vice-chairman, Department of Medicine, Ohio State University.

May 22-23—Inter-Hospital Postgraduate Lecture Series, Dr. Philip Thorek, clinical associate professor of surgery, University of Illinois, on the theme, "Practical Aspects of Surgical Problems."

SANDUSKY

A joint dinner meeting of the Sandusky County Bar and the Sandusky County Medical Society was held on March 15 at the Fremont Country Club with members' wives as guests. The Bar Association was in charge of arranging the meeting at which 75 persons were present.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland held a joint meeting with the Northern Ohio Pediatric Society on April 18.

A panel discussion on the subject, "Congenital Anomalies," was held in the late afternoon with Dr. E. W. Gerrish as moderator. The following physicians participated, emphasizing the phases indicated: Dr. A. G. Steinberg, "Genetic Aspects of Congenital Anomalies"; Dr. F. E. Nulsen, "Hydrocephalus"; Dr. D. T. Shaw, "Congenital Anomalies of Lip and Palate."

Following a social period and dinner, Dr. H. William Clatworthy, Jr., chief of the Department of Pediatric Surgery, Columbus Children's Hospital, spoke on the topic, "Surgery of Congenital Defects."

The annual "President's Meeting" was held on May 16, with Dr. Thomas D. Kinney, giving the president's annual report. Other reports also were given.

Guest speaker for the occasion was Dr. Thomas A. Dooley, who operated a hospital at Nan Tha in Viet Nam during its desperate struggle with the Communists. His topic: "Medico—A Single Candle in Laos."

It was at this meeting that the Woman's Auxiliary presented its skit, "Mink-Coated Pill."

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

STARK

The Stark County Medical Society met on April 10 in the Beldon Hotel in Canton and heard a talk by Dr. William N. Taylor, professor of



urology at Ohio State University College of Medicine, on the topic, "Urinary Fistulas."

SUMMIT

A socio-economic program was arranged for the April 1 program of the Summit County Medical Society. The general theme, "Local Medical Economic Problems," was discussed by a panel consisting of the following persons: Dr. Robert M. Bartlett, moderator; Drs. Millard C. Beyer, Glenn V. Hough, R. Franklin Jukes and Donald I. Minnig.

The Summit County Medical Society held its regular meeting on May 6. Dinner was held in the Akron City Club with the meeting following in the Auditorium of Akron General Hospital. The speaker was Dr. William L. Riker, assistant professor of surgery, University of Illinois, who spoke on "Surgery of Congenital Heart Disease." At the same meeting the "Uterine Cancer Detection" film was previewed by members before a scheduled showing by lay groups.

MAHONING

Two authorities on crash injuries spoke before Mahoning Medical Society at a special meeting April 29 in the Elks' Club. They were John O. Moore, director of the Automotive Crash Injury Research Institute of Cornell University Medical College, and Dr. Robert W. Hopkins, chief of trauma service, Cuyahoga County Hospital, Cleveland.

Moore talked on "Identification and Magnitude of the Crash Injury Problem." Dr. Hopkins spoke on "Care of the Multiple Injury Patient." The meeting was sponsored by the Youngstown trauma committee of the American College of Surgeons, with Dr. S. W. Ondash as chairman.—*Youngstown Vindicator.*

TRUMBULL

An informative discussion on "Experimental Hypertension" was presented at the April 23 meeting of the Trumbull County Medical Society. The meeting was held in the Trumbull Country Club with refreshments and dinner, followed by the discussion and a business meeting.

Joseph R. Kahn, pathologist and director of laboratories at Crile Veterans' Hospital in Cleveland, and Dr. Norman Shumway, chief of medicine at Crile Hospital, presented the discussions. They both studied with Dr. Goldblatt who made outstanding contributions to modern concepts regarding hypertension.—Society News Letter.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

A joint meeting of the Belmont County Medical Society with the Auxiliary and the Belmont County Bar Association with its Auxiliary was held on May 15 at the Belmont Hills Country Club. Dinner was followed by the program which centered around the films "Medicine and the Law," and "The Doctor Defendant."

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

MUSKINGUM

Three organizations joined forces to present a program at the Zane Hotel, Zanesville, on April 24. Sponsors were the Muskingum County Medical Society, the Licking County Medical Society and the Scientific Council of the Central Ohio Heart Association.

Speaker was Dr. A. Carlton Ernstene, chairman of the Division of Medicine, Cleveland Clinic, a vice-president of the American Heart Association, and the first president of the Ohio State Heart Association. His subject was "The Clinical Spectrum of Coronary Heart Disease."

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society had as guest speaker on April 14 Dr. Winslow Bash, Columbus, epidemiologist for the Ohio Department of Health, whose topic was "Nursery Centered Staphylococcus Outbreaks." The evening meeting was at the Nurses' Recreation Hall of the Portsmouth General Hospital where a buffet supper was served.

Dr. William A. Christopherson, professor of pathology, University of Louisville Medical School, spoke at the May 12 meeting of the Scioto County Medical Society in Portsmouth. His subject was "Cervical Cytology."

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

KNOX

Dr. Samuel L. Gerber, Cleveland, Cuyahoga County coroner, spoke at the joint meeting of the Knox County Medical Society and the Knox County Bar Association in Mt. Vernon on April 17.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

LORAIN

The April 8 meeting of the Lorain County Medical Society was held at the Oberlin Inn, Oberlin. Sixty-five members were present.

Mrs. H. A. Zealley, new executive secretary, was presented. Dr. Myers also announced the

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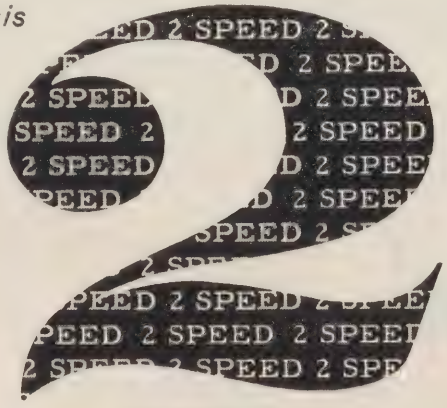
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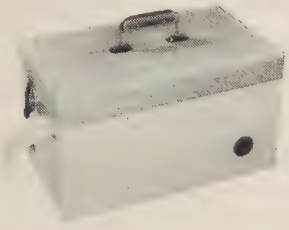


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opening of the Society's office: Room 311, Elyria Block Bldg., Elyria.

Jonas Marukas, Ph. D., clinical chemistry, was elected Honorary Member. Dr. Robert Vandervort, Elyria, and Dr. Abraham Klar, Lorain, were both accepted as associate members of the Society.

The major portion of the meeting was devoted to insurance, and adoption of the Ohio State Medical Council recommendation concerning Third Party Medical Care Plans.

The Annual Lorain County Medical Symposium was announced. This was scheduled at the Oberlin Inn, May 7.

The eleventh Annual Symposium sponsored by the Lorain County Medical Society was held May 7 at the Oberlin Inn, with 99 members and guests in attendance. The speakers were all from the faculty of the School of Medicine of Western Reserve University. The program arranged by Dr. R. G. Thomas of Elyria was as follows:

"Management of Carcinoma of the Cervix"—Dr. Edward J. Quilligan, asst. professor of obstetrics and gynecology.

"Recent Accomplishments in Cardiovascular Surgery"—Dr. Jay L. Ankeney, senior instructor in thoracic surgery.

"The Postmature Infant"—Dr. Charles McClelland, asst. clinical professor of pediatrics.

"The Basis for Anti-Hypertensive Therapy"—Dr. Robert F. Williams, asst. professor of medicine.

Following the cocktail hour and dinner there was a brief business meeting, at which time Dr. J. R. Bay was elected to active membership. The after dinner speech was presented by Dr. Jack Cole, associate professor of surgery, on "Management of Polyps of the Colon."

Seventeen members of the intern and resident staffs of the Elyria Memorial and St. Joseph's Hospitals were guests of the Society at the Symposium and dinner.—L. C. Meredith, M. D., Secretary-Treasurer.

AMEF Board Is Increased To 15 Members

Foundation President George F. Lull has announced that four new members have been added to the board of directors of the American Medical Education Foundation, expanding the board from 11 to 15 members. They are: Dr. Lowell T. Coggeshall, Chicago; Dr. Hugh H. Hussey, Washington; and Dr. Dwight Murray, Napa, Calif., and Dr. Walter B. Martin, Norfolk, Va., both recent past presidents of the AMA.

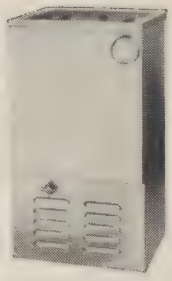
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New Members of OSMA

The following are the names of the new members of The Ohio State Medical Association since April 1st, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County

Georg Bosse, Cleveland
Robert E. Dunn, Cleveland
James P. Frackelton, Westlake
Richard F. Grochocki, Cleveland
George L. Hoffmann, Jr., Cleveland
Elwood G. Nader, Cleveland
Linell L. Rodgers, Cleveland

Franklin County

Robert C. Anderson, Columbus
Jack C. Bass, Columbus
Ollie E. Southard, Columbus

Hamilton County

Gertrude B. Brecht, Cincinnati
Joseph D. Broderick, Cincinnati
Robert G. Burt, Cincinnati
Norton Dock, Cincinnati
David W. Elliott, Cincinnati
Charles D. Feuss, Jr., Cincinnati
Stanley J. Lucas, Cincinnati
Lloyd E. Owens, Terrace Park

Lucas County

Mary A. Lenkay, Toledo
Franz B. Ruwe, Toledo
John L. Zimmerman, Toledo

Montgomery County

Gene P. Omlor, Dayton
William D. Roberts, Dayton
Charles E. M. Wenyon, Dayton
John R. Whitaker, Dayton

Ross County

Carl A. Henderson, Chillicothe

Seneca County

Maria Garlo, Tiffin

Summit County

Leslie A. Fink, Akron
Samuel C. Hardy, Akron
Thomas R. Kelly, Akron
Francis C. Meszaros, Akron
John D. Morley, Akron
Ernest H. Planck, Jr., Akron

Wyandot County

Walter B. Nozniak, Carey

Cincinnati Area General Practitioners Discuss E. N. T. Problems

The Southwestern Ohio Society of General Physicians met on March 9 for a program on "E.N.T. Problems and Allergic Respiratory Disease," in collaboration with the University of Cincinnati College of Medicine.

Guest speaker was Dr. E. L. Derlacki, associate professor, Department of Otolaryngology, Northwestern University Medical School. Local physicians participating included Dr. William C. Thornell, Dr. Henry M. Goodyear, Dr. Ray Hilsinger, and Dr. Albert R. Zoss.

Service Award Winner Is Honored By Puerto Rico Legislature

Dr. Tom Douglas Spies of Birmingham, Ala., who received the AMA Distinguished Service Award at the New York meeting in June of last year, was honored recently in a joint resolution adopted by the Senate and House of Representatives of the Commonwealth of Puerto Rico. The Puerto Rico resolution honored Dr. Spies specifically for bringing to the island the first doses of folic acid and vitamin B-12 to be used experimentally in cases of sprue.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES—SUMMER, 1958

SURGERY—Surgical Technic, two weeks, July 21, Aug. 18. Basic Principles in General Surgery, two weeks, July 7. International College of Surgeons General Surgery Course, two weeks, July 7. Surgical Pathology, two and four weeks, by appointment.

GYNECOLOGY—Vaginal Approach to Pelvic Surgery, one week, July 14.

FRACTURES—Clinical Course, two weeks, by appointment.

PEDIATRICS—Clinical Course, two weeks, by appointment. Neuromuscular Diseases, Cerebral Palsy, two weeks, July 7.

RADIOLOGY—Clinical Diagnostic X-Ray, two weeks, by appointment.

UROLOGY—Cystoscopy, ten-day practical course, by appointment.

DERMATOLOGY—Clinical Course, by appointment.

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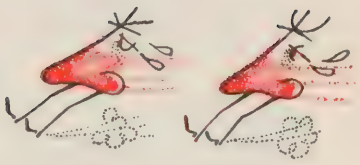
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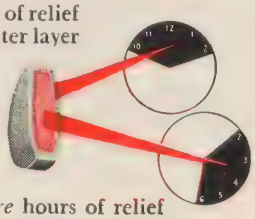
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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio
(See Page 697 for roster of officers.)

FAIRFIELD COUNTY

Woman's Auxiliary to Fairfield County Medical Society had a luncheon on April 8 at the Lancaster Country Club. Thirty-five ladies in spring attire attended this special guest day meeting. The hostesses were Mrs. Fred Jones, Mrs. R. A. Welsh and Mrs. J. Hoodlett.

In the absence of the president, Mrs. G. LeSar, Mrs. Chas. Clark, vice-president, presided. Mrs. Jas. Beasley introduced the guest speaker, Mrs. C. E. Wintringham of Ada who held the attention of the group with her chalk drawings and philosophical monologue.

The Lancaster-Fairfield Hospital Nurses' Home was the meeting place on April 25 for 122 High School juniors and seniors. The following schools were represented:

Liberty Union; Berne Union; Carroll; Rushville; Thornville; Millersport; Pleasantville; Hebron; Newark; Canal Winchester; Pickerington; Thurston; Amanda; Lancaster High School and St. Marys High School. Each spring the Woman's Auxiliary to the Fairfield County Medical Society gives interested high school students an opportunity to learn more about the profession of modern nursing.

Student nurses conducted the girls through the hospital and the nurses' home, pamphlets on Nursing Careers were available for those interested, and refreshments were served from an attractive tea-table in the library.

Mrs. Chester Swett, general chairman for the tea, was assisted by a committee of several Auxiliary members.

LUCAS

It was guest day at the Academy of Medicine April 8, where members of the Auxiliary to the Academy invited representatives of other city-wide organizations to meet for dessert luncheon and to hear Kevin McCann, president of Defiance College and special assistant to President Eisenhower.

Hostesses for the meeting were Mrs. Harold Shapiro and her co-chairman, Mrs. J. B. Hirsch, assisted by a committee.

Dr. Myron Means, past adviser to the auxiliary from the Academy; Dr. Harvey Gunderson, president of the Academy; and Mrs. V. R. Frederick, president of the State Medical Auxiliary, were among the especially invited guests.

A short business meeting was presided over by Mrs. David Katchka, Auxiliary president.

Mrs. C. J. A. Paule announced the winners in the American Physician and Surgeons' Essay Contest sponsored recently in schools. First prize went to Kenneth Alexander, Whitmer High School. Second prize was won by Robert Dopler, Central High and third went to Shirley Ann Wyse of Archbald German High.

MAHONING

Mrs. Earl H. Young was elected president of the Woman's Auxiliary to the Mahoning County Medical Society for the coming year at the annual business meeting which followed a luncheon Wednesday, April 15, at the Pick-Ohio Hotel. Mrs. Cary S. Peabody, the retiring president, presided.

With other new officers, Mrs. Young was formally installed at a dinner May 7, at Youngstown Country Club. The program featured a skit which was directed and produced by members of the group.

Mrs. A. E. Rappoport was named president-elect, Mrs. C. E. Pichette, vice-president, Mrs. Edward G. Rizk, recording secretary, Mrs. James A. Patrick, corresponding secretary, and Mrs. Edward M. Thomas, treasurer. The report of the nominating committee was submitted by Mrs. Craig C. Wales.

Dr. Allen Schmuller of Westminster College, presented as guest speaker by Mrs. Rizk, the program chairman, gave an illuminating review of the situation facing colleges and universities today.

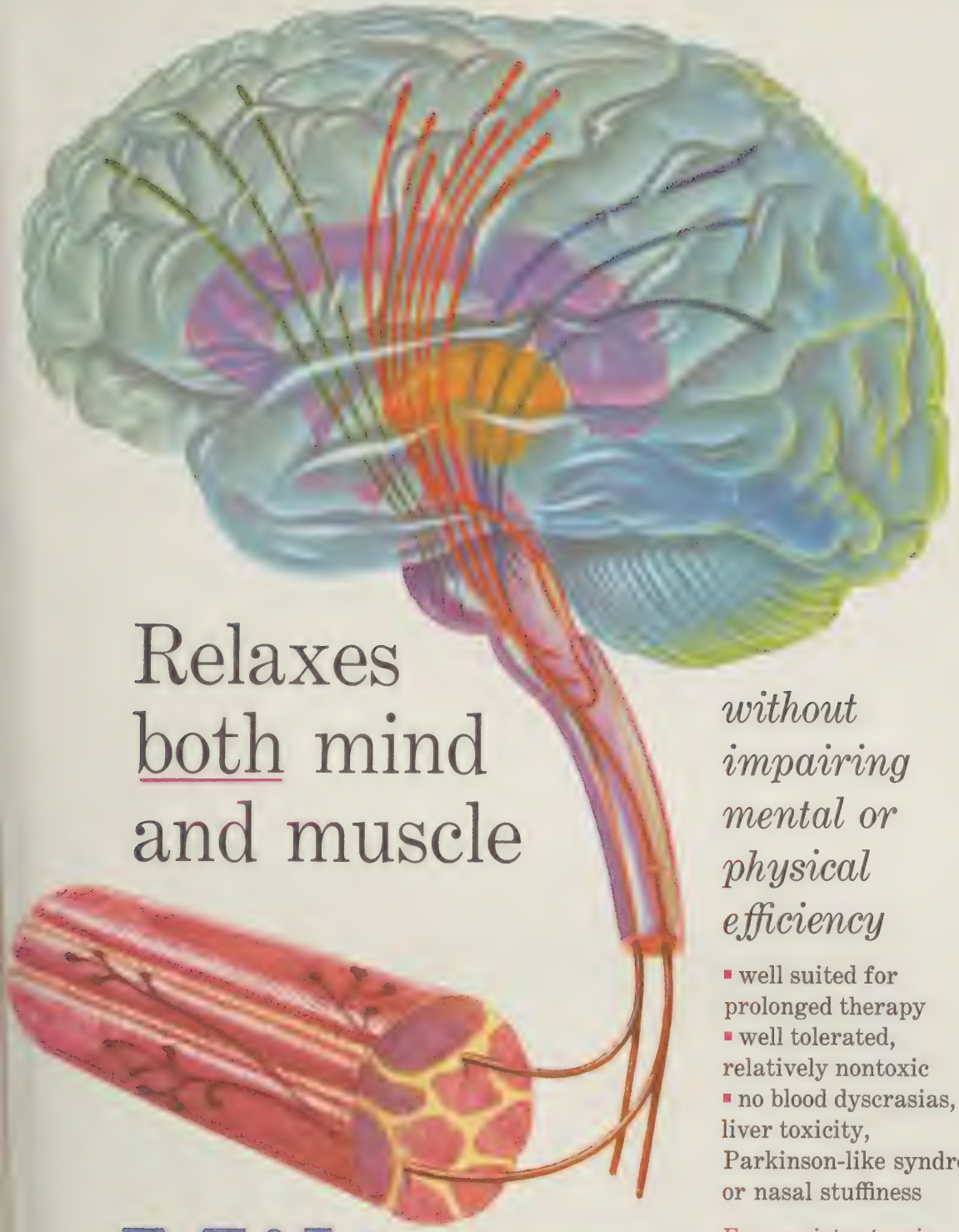
Mrs. Young gave the invocation. Mrs. Wayne Agey, legislation chairman, urged the members to vote in the coming election. Mrs. S. G. Patton, Jr., gave a comprehensive report on civil defense and asked members to attend the special classes being offered by the local Civil Defense Corps.

MIAMI

On April 12 the Woman's Auxiliary to the Miami County Medical Society sponsored a dance at the Troy Country Club. The proceeds will provide tuition for two girls through the nurses training school of their choice.

Chosen because of their excellent credentials are Mary Hemmert and Nancy Smith, both of local area.

Miss Hemmert, daughter of Mrs. Clifford A. Hemmert of Rt. 1, Piqua, a graduate of Piqua Catholic High School, will enter training next summer at Good Samaritan Hospital, Dayton. Miss Smith, graduate of Bradford High School, will train at Miami Valley Hospital, Dayton. She



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SCIOTO

A personally conducted tour of the historical museum of Dr. Paul E. Bennett highlighted the April meeting of the Woman's Auxiliary to Scioto County Medical Society. Dr. Bennett's museum contains Indian relics and unusual archaeological findings from this area as well as objects of historical interest from various countries.

The doctor was assisted in conducting the tour by Ralph Servey.

The tour followed a 1:30 dessert and business meeting at the home of Mrs. A. L. Berndt. Mrs. Berndt was assisted by Mrs. Carl Braunlin and Mrs. Ross Moore Gault.

At the business meeting conducted by Mrs. William C. Hugenberg, reports were made by the following committee chairmen: Mrs. Joseph T. Gohmann of the nurse recruitment committee on the tea and tour of Mercy Hospital, School of Nursing in February; Mrs. Howard E. Baughman, Jr., health magazine subscription; Mrs. Robert N. Counts, ways and means; Mrs. Samuel L. Meltzer, radio health reporter program, and Mrs. Jerome Sheets, national bulletin.

Mrs. J. P. McAfee, chairman of the American Medical Education Foundation, reported that she has sympathy and memorial cards for those wishing to contribute to the foundation, which was established in 1951 by the American Medical Association for private support of medical schools in this country and for expanding medical education. Mrs. McAfee also reported that the auxiliary is contributing a memorial to the foundation in memory of the late Mrs. Frederick Gillig.

As a service of the AMA, members were given family health record booklets by Mrs. Armin Melior for distribution among other organizations and for patients in local hospitals.

Delegates to the state auxiliary convention in Cincinnati were Mrs. Hugenberg and Mrs. Melior, the alternate delegate Mrs. William Singleton.

Plans were made for entertainment of the wives of doctors who were scheduled to attend the General Practitioners District meeting in Portsmouth.

STARK

April 23, the president's gavel of the Woman's Auxiliary to the Stark County Medical Society was handed to Mrs. R. K. Ramsayer by the outgoing president, Mrs. R. G. Spitzer. Sixty members were present for the luncheon and election at Massillon Woman's Club.

Mrs. Lloyd Dowell of Massillon was voted president-elect.

Other new officers are Mrs. Harry W. Beck,

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vice-president; Mrs. Henry Clapper, corresponding secretary; Mrs. Frederick J. Raisch, recording secretary; Mrs. Frank Schirack, Treasurer, and Mrs. William Bogedain, assistant treasurer.

The three top winners of the American Physicians' and Surgeons' essay contest sponsored recently in schools by the auxiliary were guests at the meeting. They are Miss Janet Holshoy of Jackson High School, Miss Shirley Ann Rocovitz of Lehman and Miss Wilma Whiteley of Northwest High School. Certificates of merit were presented the three winners. Mrs. Howard Ickes, contest chairman, submitted her final report.

Mrs. Spitzer reported on the state convention held in Cincinnati. Together with other local auxiliaries, the Stark County Auxiliary received a certificate showing it is a component unit of the Woman's Auxiliary to the Ohio State Medical Association. Other awards were for the best program in an auxiliary of more than 200 members and a certificate of appreciation for donating more than $1,000 to the American Medical Education Fund.

Delegates to the convention were Mrs. Mark Herbst, Mrs. John Seesholtz and Mrs. William White.

During the program, Mrs. J. Atlee Frederick reviewed the book, *Don't Eat the Daisies.*

A spring decorating theme featuring yellow flowers and foliage decorated the tables. Mrs. Roy H. Clunk served as chairman with the Massillon members as hostesses.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for a luncheon April 1 at the Woman's City Club, Akron.

Mrs. R. R. Pliskin presided at the business meeting which included the election of the following officers for the year 1958-1959:

President, Mrs. Devitt L. Gordon; president-elect, Mrs. Robert J. Hemphill; vice-president, Mrs. Carl T. Korsmo; recording secretary, Mrs. A. H. Loomis; corresponding secretary, Mrs. B. F. Suffron; treasurer, Mrs. Robert S. McMillen.

Delegates to State Convention April 15-17, in Cincinnati were:

Mrs. Philip B. de Maine, Mrs. Joseph J. Eckert, Mrs. H. E. Muller. Alternate, Mrs. Donald I. Minnig.

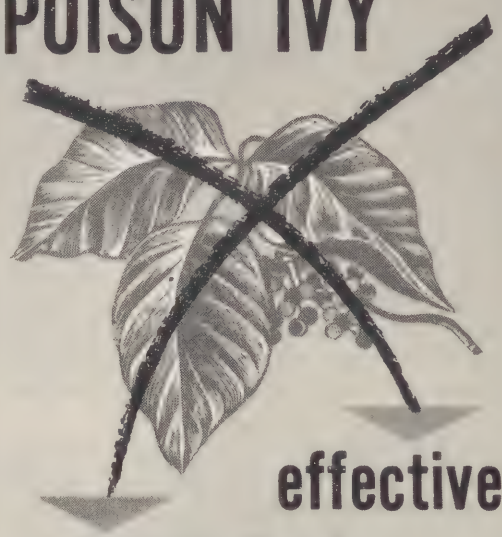
Mrs. H. W. Allison, program chairman, introduced the speaker Mrs. Ralph W. Kelly from Rocky River. Frances Kelley, Cleveland musician, entertained with vocal and piano illustrations of well known operas.

Again the table centerpiece was auctioned for AMEF. This brought the total for the year to $319.57.

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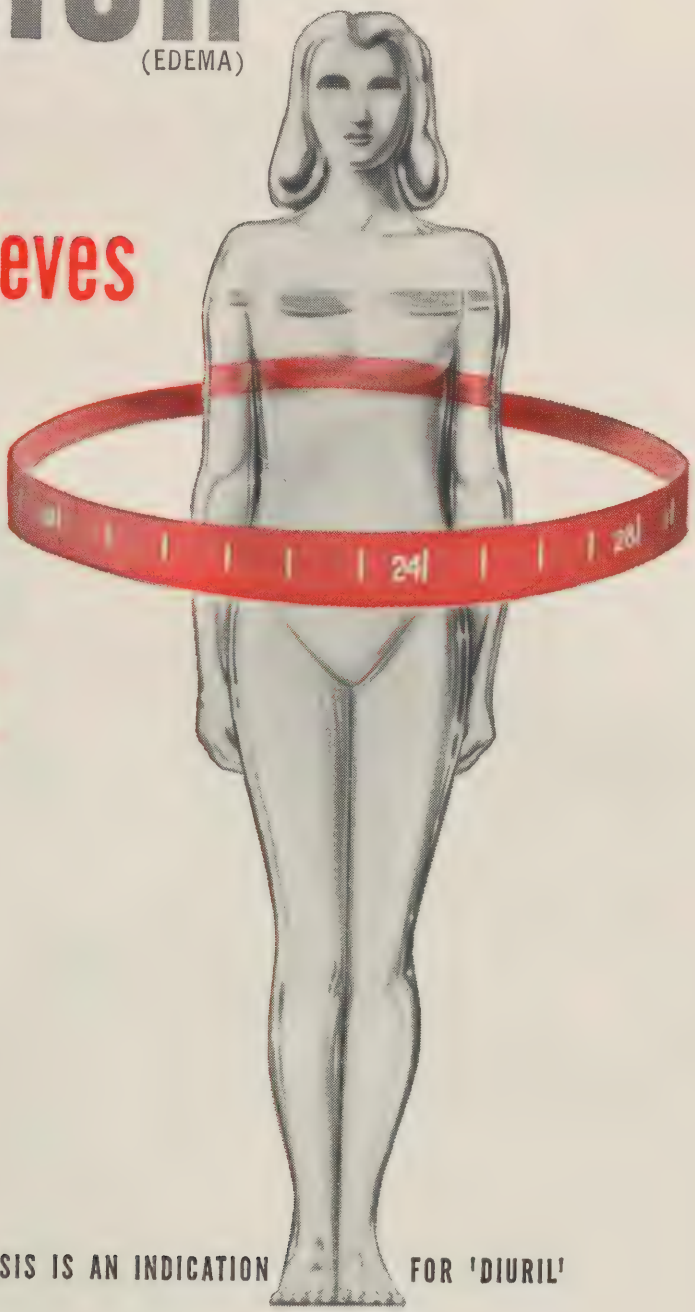
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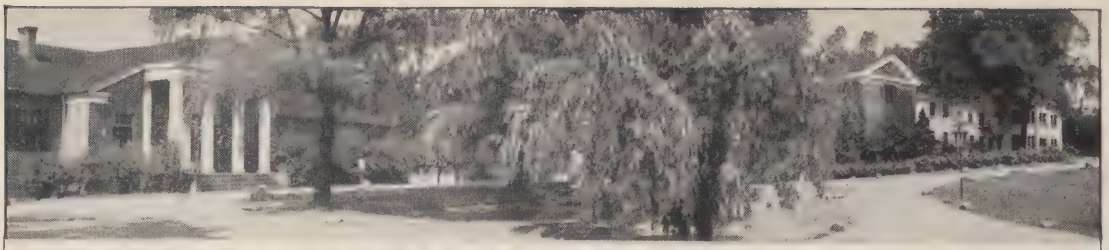
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1. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. *6*:580 (April) 1955.
2. Codling, J. W., and Lowden, R. J.: Northwest Med. *57*:331 (March) 1958.

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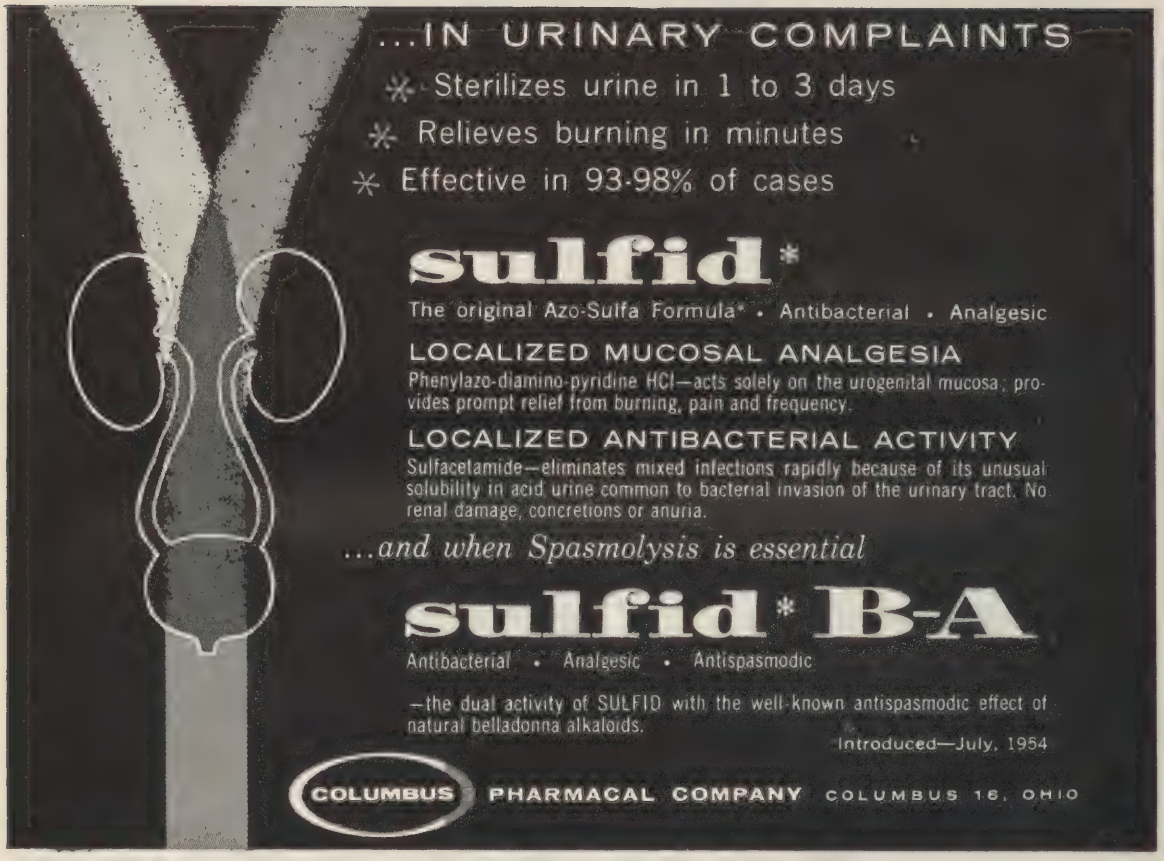
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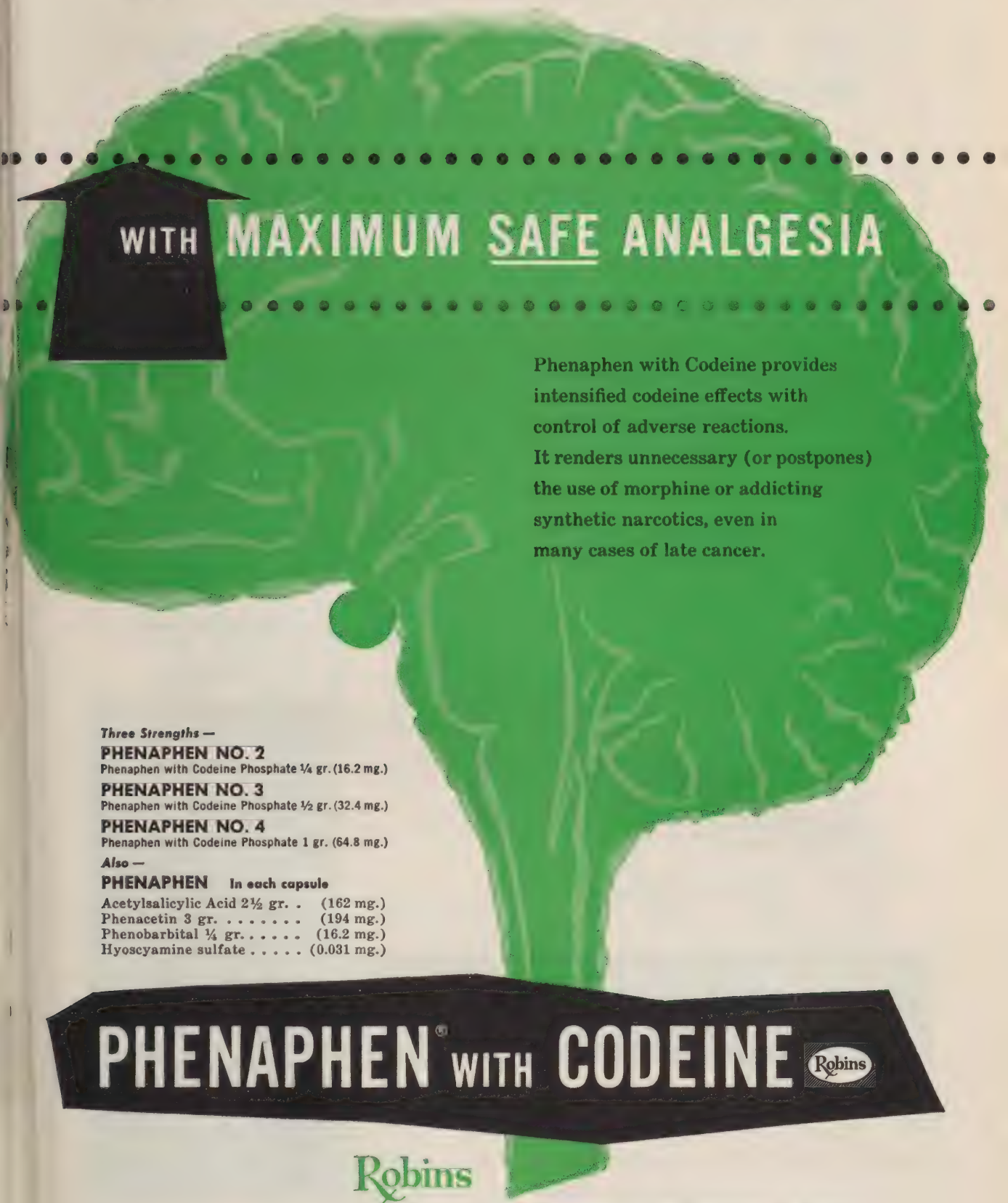
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Ohioans To Participate on National Chest Physicians Program

Several Ohio physicians will participate on the program for the 24th Annual Meeting of the American College of Chest Physicians. The meeting is in San Francisco, Calif., June 18-22. Ohioans included on the program are the following:

Dr. B. L. Brofman, director, cardiovascular research, Mount Sinai Hospital, Cleveland, will participate in a discussion on "Coronary Disease Including Medical and Surgical Therapy."

Dr. Karl P. Klassen, chief of the thoracic surgery service, Ohio State University, Columbus, will discuss the subject, "Biopsy Procedures in Chest Diseases."

Drs. Neil C. Andrews, chief of surgery, Philip C. Pratt, chief of laboratories and A. J. Christoforidis, chief of radiology, Ohio Tuberculosis Hospital, Columbus, are co-authors of a paper to be presented entitled, "Bronchogenic Cysts in Patients Presumed To Have Pulmonary Tuberculosis."

Dr. Earle B. Kay, director of cardiovascular surgery, St. Vincent's Charity Hospital, Cleveland, will participate as a panel member in a "Clinical Cardiac Conference."

Dr. F. Mason Sones, Jr., director, Cardiac Catheterization Laboratory, Cleveland Clinic Foundation, will present a paper on "Intercardiac Anatomy in Patients with Congenital Heart Lesions."

Dr. Henry A. Zimmerman, chief of the cardiovascular service, St. Vincent's Charity Hospital, Cleveland, will participate in a round table discussion on the subject, "Selection of Patients for Surgery with Acquired Valvular Lesions."

Dr. Ray W. Kissane, professor of medicine in cardiology, Ohio State University, will participate in a discussion on "Trauma and Heart Disease (Rehabilitation)."

Dr. Joseph F. Tomashefski, assistant professor of medicine and physiology, Ohio State University, will take part in a round table discussion of the subject, "The Evaluation of Disability in Industrial Lung Diseases."

Dr. Earl T. Carter, assistant professor of preventive medicine and physiology, Ohio State University, will take part in a discussion on "Problems in the Selection of Patients for Travel by Air—Present and Future."

The Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, is offering predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1959. Deadline for applications is October 31, 1958.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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COMING MEETINGS

Ohio State Medical Golfers Association, 33rd Annual Tournament, Springfield Country Club, June 13; Robert Ellwell, 3101 Collingwood Blvd., Toledo 10.

American Medical Association, Annual Session, San Francisco, June 23-27.

West Virginia State Medical Association, Annual Meeting, White Sulphur Springs, W. Va., August 21-23.

Ohioans Participate in Minnesota State Association Meeting

Two Ohioans were among the guest speakers at the 105th Annual Meeting of the Minnesota State Medical Association, May 22-24 at Minneapolis. Dr. James W. Reagan, associate professor of pathology and director, Laboratory of Cancer Research, Western Reserve University School of Medicine, Cleveland, spoke on "The Cell as a Mirror of Disease." Dr. R. W. Kissane, clinical professor of medicine, Ohio State University College of Medicine, Columbus, participated in a panel discussion on "Medico-Legal Aspects of Heart Disease."

Berea—Brook Park Grange members were told by Dr. Edward Chester about the structure of the heart, its functions, diseases and operative repairs.

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REFERENCES: (1) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M.A.J.* 77:844 (Nov. 1) 1957. (2) Schneierson, S. S.: *J. Mt. Sinai Hosp.* 25:52 (Jan.-Feb.) 1958. (3) Hasenclever, H. F.: *J. Iowa M. Soc.* 47:136, 1957. (4) Rhoads, P. S.: *Postgrad. Med.* 21:563, 1957. (5) Caswell, H. T., and others: *Surg. Gynec. & Obst.* 106:1, 1958. (6) Josephson, J. E., & Butler, R. W.: *Canad. M.A.J.* 77:567 (Sept. 15) 1957. (7) Petersdorf, R. G.; Curtin, J. A., & Bennett, I. L., Jr.: *Arch. Int. Med.* 100:927, 1957. (8) Waisbren, B. A., & Strelitzer, C. L.: *Arch. Int. Med.* 101:397, 1958. (9) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957. (10) Murphy, J. J., & Rattner, W. H.: *J.A.M.A.* 166:616 (Feb. 8) 1958. (11) Neter, E., & Hodes, H. L.: *Pediatrics* 20:362, 1957. (12) Woolington, S. S.; Adler, S. J., & Bower, A. G., in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 365.

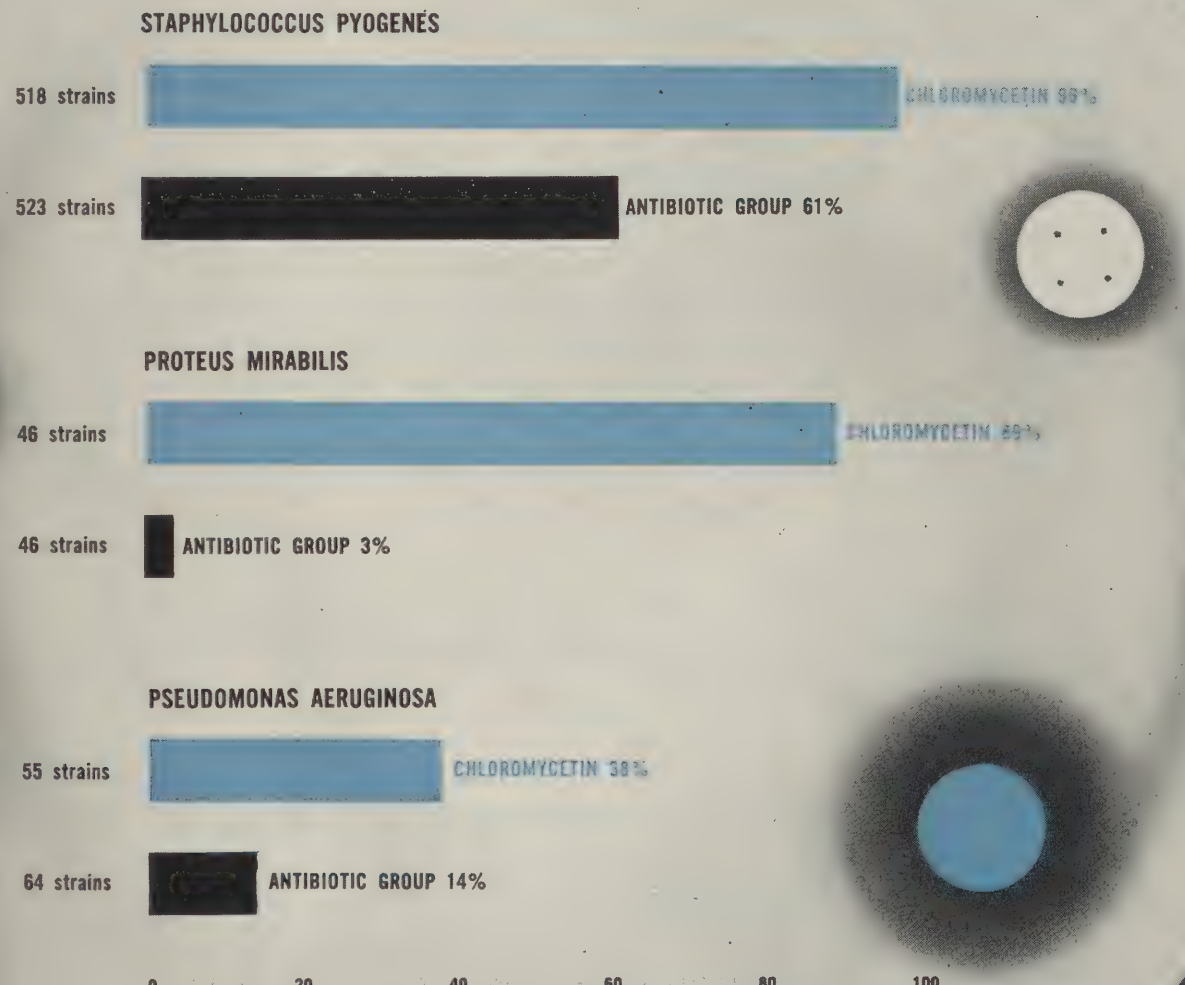
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The Ohio State Medical Journal

Vol. 54 July, 1958 No. 7

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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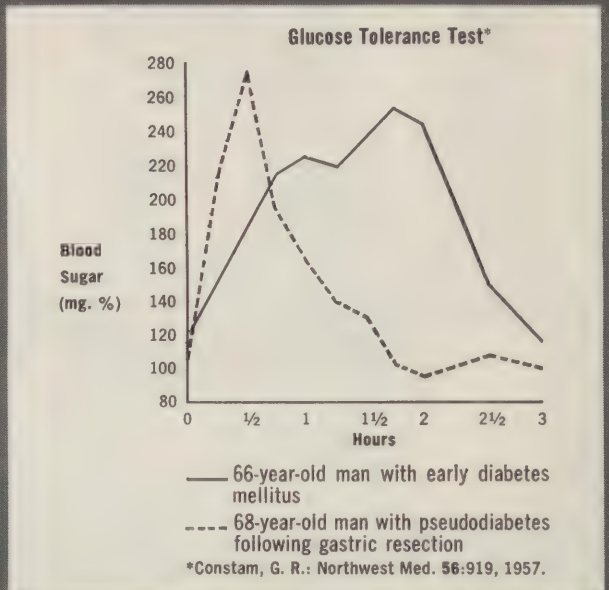
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LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

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COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mrs. Mary B. Herald, Executive Secretary, 125 Commerce Street, Youngstown 3. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

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COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

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JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Shaffer, Secretary, Toronto. 3rd Tuesday, monthly.

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TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

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FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

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FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

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ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

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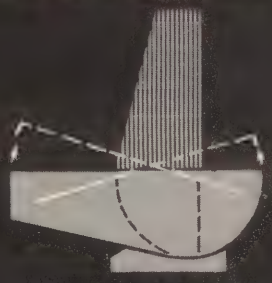
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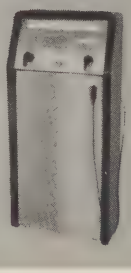
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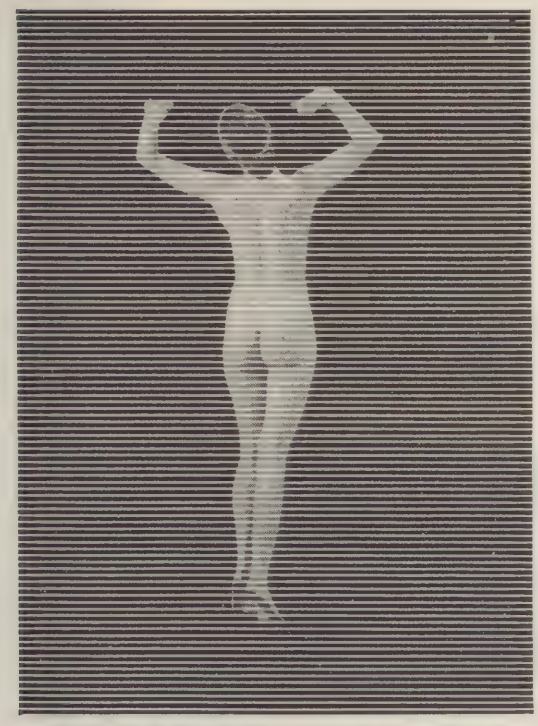


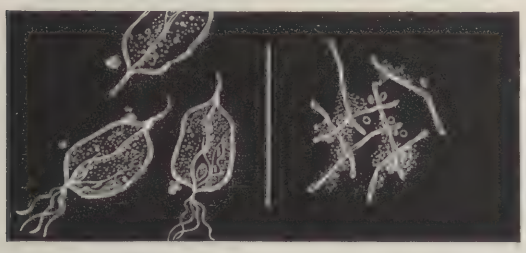
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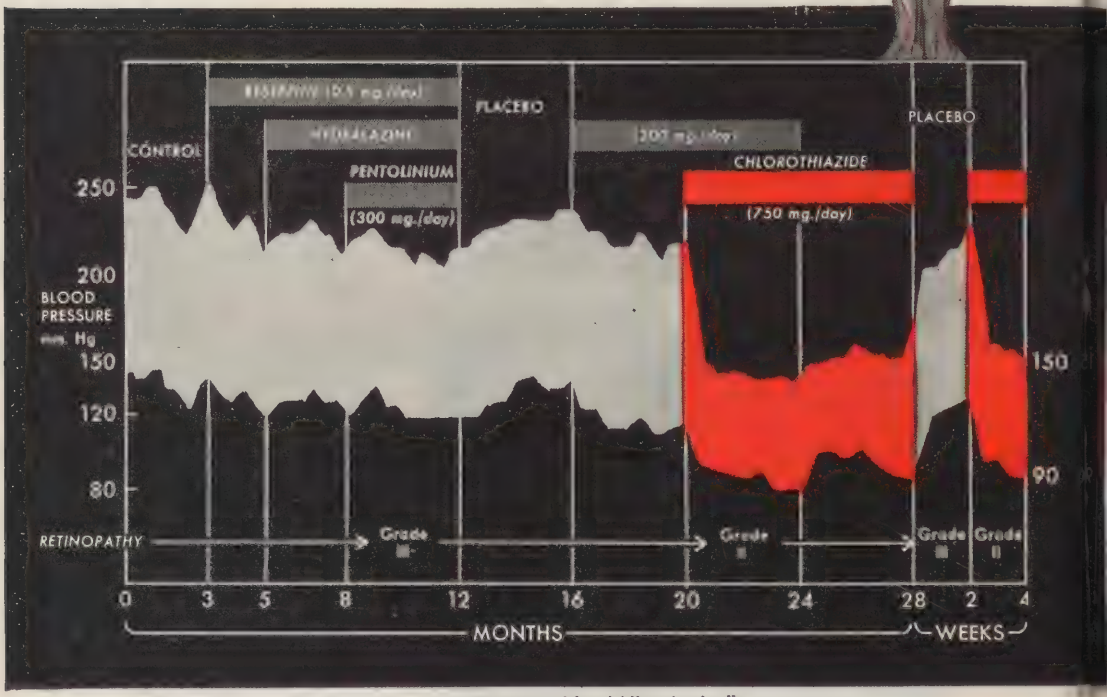
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Handbook of Medical Treatment, by Milton J. Chatton, M. D., Sheldon Margen, M. D., and Henry Brainerd. ($3.00, 5th edition, *Lange Medical Publications, Los Altos, California.* This still continues to be the best handbook on medical treatment to meet the needs of the medical student and practitioner, either in his white jacket or in his bag. Of course, it had its origin and still has its roots in the medical school of the University of California, in San Francisco.

Surgery in World War II: Orthopedic Surgery in the Mediterranean Theater of Operations: Editor-in-Chief, Colonel J. B. Coates, Jr., Editor for Orthopedic Surgery, Mather Cleveland, M. D. ($4.00, *Office of the Surgeon General, Department of the Army, Washington 25, D. C.)* This volume will prove of great interest to all medical officers who served in the Army whether they have returned to civil life or not. It is a record of the outstanding services which these physicians rendered during the conflict. It will serve also as a source of information to the medical student who now or will follow them into the medical services of the Armed Forces.

Healthful School Living, by Charles C. Wilson, M. D. ($5.00, *National Education Association, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.)* A report of the Joint Committee of the two societies with the cooperation of many contributors and consultants.

Lymphatics Lymph and Lymphoid Tissue, by J. M. Yoffey and F. C. Courtice. ($10.00, *Harvard University Press, Cambridge 38, Mass.)* This edition is essentially a new book and is a most complete review of the subject. Researchers in medicine and immunology will need a copy for ready reference.

Experimental Psychopathology, by Paul Hoch, M. D. and Joseph Zubin, Ph.D. ($6.50, *Grune & Stratton, Inc., New York 16, New York.)* Since the days of Kraepelin, Bleuler, Jaspers, et al., psychopathology has progressed from description to experiment. This means that sooner or later the subject will get on a scientific basis. This volume brings us up-to-date on these early attempts to do so.

Six Children, by Estelle J. Foote, M. D. ($5.50, *Charles C. Thomas Publisher, Springfield, Illinois.)* This book is based upon the complete study by examination of the author of over 3600 children. It offers much fresh material for diagnosis and advice. Emphasis is placed upon full family history, personal characteristics as seen by parents; the child's progress in school and his characteristics as seen by the teacher; accurate determination of his real progress in each of his school's subjects; psychometric tests; and finally physical examination and interview.

Mental Health in Childhood, by Charles L. C. Burns, M. D. ($2.75, *Fides Publishers Association, Chicago 19, Illinois.)* A well known British psychiatrist of Birmingham Child Guidance Service writes as a parent as well as an expert. He outlines in non-technical terms the development of the child and the ways difficulties can arise.

Treatment of Burns, by Curtis P. Artz, M. D. and Eric Reiss, M. D. ($7.50, *W. B. Saunders, Philadelphia 5, Pa.)* This is designed as a guide for the treatment of burns in accordance with present-day knowledge. An unique feature is the emphasis upon the art as well as the science of medicine.

Alcoholism: A Treatment Guide for General Practitioners, by Donald W. Hewitt, M. D. ($3.00, *Lea & Febiger, Philadelphia 6, Pa.)* This is believed to be the first book of its kind intended primarily for the general practitioner to help him meet the widespread need for specific management, treatment and follow-up therapy of alcoholism as it is encountered on all social levels. The work is based on the successful results obtained from treating an average of 100 alcoholics a month in the largest alcholoic rehabilitation center of its kind in the western United States. Dr. Hewitt establishes a new understanding and sympathy on the part of the physician, and stresses the vital need to secure the confidence and cooperation of his alcoholic patient's family and friends. The necessary steps which must be taken —and how to take them—are outlined clearly. Antabuse, Thorazine, Sparine, and other currently accepted drugs are included in the sections on therapy.

Alcoholism, by Harold E. Himwich, A Symposium of AAAS: ($5.75, Publication No. 47. *American Association for the Advancement of Science, 1515 Massachusetts Ave., N.W., Washington 5, D. C.)* Deals with psychiatric, physiologic social and interpersonal aspects of the problem leaving the reader to draw his own conclu-

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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sion as to the moral aspects. Our own Chauncey D. Leake wrote the introduction setting the stage historically, and Fred Hitchcock helped arrange the symposium. The multi-disciplinary facts of AAAS facilitates this sort of a presentation.

The Legacy of Doctor Wiley, by Maurice Natenberg with an introduction by Jonathan Forman, M. D. ($3.00, *Regent House, Chicago 40, Illinois.)* The author of this book has done a great service in recalling to the younger generation the life and works of Harvey W. Wiley, M. D. The thesis is that in these days when nearly a thousand chemicals are added to our food the effects of which we are for the most part ignorant, and that the original Pure Food and Drug Act would be adequate if amended and properly enforced. The second half of the book deals with the many dangers we are faced with through evasion and hamstringing combined.

Health Year Book: 1956, by Oliver E. Byrd, M. D. ($5.00, *Stanford University Press, Stanford, Calif.)* The author read 2000 articles in some 300 medical journals and selected 254 articles for review. Consequently this book offers a good cross section of programs in health matters.

Integrated Anatomy and Physiology, by Carl C. Francis, M. D. and Gordon L. Farrell, M. D. ($5.85, 3rd ed., *C. V. Mosby, St. Louis 3, Mo.)* Written in the belief that structure cannot be understood without a knowledge of function and it is impossible to discuss function without a basis of structure. The result is an excellent text for the student who requires a basic knowledge of the human body.

The World Health Organization, A Study in Decentralized International Administration, by Robert Berkov, ($4.50, *Gregory Lounz, Distributing Agent, 11 E. 45th St., New York 17, N. Y.)* This study analyzes the structure of WHO, assesses the effects of its policy of decentralization and draws general conclusions as to the success decentralization might play in the successful administration of international programs.

Rypin's Medical Licensure Examinations, by Walter L. Bierring, M. D. ($10.00, 8th edition, *J. B. Lippincott Co., Philadelphia 5, Pa.)* Contains topical summaries and a list of questions well designed to help anyone preparing for such an examination. Each section has been prepared by a recognized authority.

Calderwood's Orthopedic Nursing, by Carroll B. Larson, M. D. and Marjorie Gould, R. N. ($5.75, 4th ed. *C. V. Mosby Company, St. Louis 3, Missouri.)* Primarily this edition brings in new procedures of treatment which have evolved as a natural sequence of progress in orthopedic surgery. Secondly, the book presents improvements which have resulted from collected criticisms of the last edition which have been made in several areas. This edition will undoubtedly be as well accepted as the previous one.

Forest Doctor: The Story of Albert Schweitzer, by Wm. Cecil Northcutt. ($1.50, *Roy Publishers, New York 21, N. Y.)* Albert Schweitzer, the forest doctor of Lamdrene in French Equatorial Africa spent 40 years of his life in this forest hospital. What made him—musician, philosopher, theologian—leave Europe for Africa? The answer makes one of the most thrilling tales of our time.

A Manual of Pharmacology, by Torald Sollman, M. D. ($20.00, 8th ed., *W. B. Saunders Co., Philadelphia 5, Pa.)* For more than forty years this manual has been kept up to date by the distinguished pioneer in modern pharmacology at Western Reserve University. He has offered a critical summary of all significant contributions to the field. In spite of all efforts to keep the text within bounds it contains 1535 pages.

Biochemical Problems of Lipids, by G. Popjak and E. Le Breton. ($10.75, *Interscience Publishers, Inc., New York 1, N. Y.)* This is the proceedings of the second International Congress held at the University of Ghent, organized with the collaboration of the Zlaanse Chemische Vereniging of Belgium under the presidency of Professor R. Ruyssen.

Epilepsy: Grand Mal, Petit Mal, Convulsions, by Letitia Fairfield, M. D. ($4.75, *Philosophical Library, Inc., New York 16, N. Y.)* This is the first full-length British book to summarize for the public exactly what is known about the various forms of this disease, what treatments are available, what special problems are presented by epilepsy in children, and what employment the epileptic can expect to find for himself in the workaday world. The reading of this book will help epileptics to get their troubles in proper perspective and it makes a pretty good review for us physicians who are not constantly in touch with this problem.

Surgeons All, by Harvey Graham, M. D. with foreword by Oliver St. John Bogarty. ($10.00, *Philosophical Library, Inc., New York 16, N. Y.)* This story of a thousand and one surgeons was first published a few months before Hitler's invasion of Poland. Despite numerous and excellent reviews the book naturally did not achieve the wide sales that it deserved owing to the restrictions of the war. Since that time many important

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Judaism and Psychiatry: Two Approaches to the Personal Problems and Needs of the Modern Man, by Simon Noveck. ($3.95, *Basic Books Publishing Company, New York 3, N. Y.)* Adding a new dimension to the understanding of the Jewish way of life and its relevance to the pressures of contemporary living, this book by 16 prominent psychoanalysts and rabbis is the first to point up the psychological soundness of Jewish teachings and the contributions that they can make to the resolution of personal problems.

Obesity: Its Cause, Classification and Care, by E. Philip Gelvin, M. D. and Thomas H. McGavack, M. D. ($3.50, *Harper and Brothers, New York 16, N. Y.)* This gives us from the benefits of the authors' 10 years' experience in a specialized obesity clinic a simple yet effective program which can readily be applied to office practice, incorporating all the new knowledge that we have in chemistry, in physiology. It offers no panacea or anything sensational or magical but it does give us an integrated program for the person who desires to control this disease.

Year Book of Endocrinology 1956-57 Series, by Gilbert S. Gordan, M. D. ($6.75, *Year Book Publishers, Chicago 11, Ill.)* Rapid moving advances in endocrine chemistry have virtually revolutionized previous concepts of the nature of hormones and therefore a book such as this of intelligently selected articles for review and comment by competent personnel is something that every physician, no matter what his interests in medicine, will do well to study.

Science Looks at Smoking, by Eric Northrup, with introduction by Dr. Harry F. M. Greene, Chairman, Department of Pathology, Yale University. ($3.00, *Coward - McCann, Inc., New York 16, N. Y.)* Among scientists there is always the one who is a stickler for the last bit of evidence to be all in before any conclusions be drawn, and there is the imaginative scientist who emphasizes the general trend of the evidence. This we find in discussion of all human poisons, cancer research, chemical additives to foods, influence to fertilizer in the soil upon plants, etc. Here a well-known science writer has made a serious effort to inquire into the effects of smoking and appraise the reports that have been so widely circulated. The book points out the faulty research methods and the preconceived attitudes that have made suspect some of the publicized conclusions on smoking as a cause of lung cancer and failure. Since there are two sides to this question this popular presentation of Dr. Greene's analysis of the situation is very much worth while for every doctor to read before he comments on this controversy to his patient.

Guerrilla Surgeon: The Adventures of a New Zealand Doctor in Yugoslavia, by Lindsay Rogers. ($3.95, *Doubleday and Company, Garden City, New York.)* Lindsay Rogers is a surgeon, a highly skilled and tenacious battler against suffering and death and this is the story of how he used his skills to aid the Yugoslav partisans in World War II. During the German occupation of the Balkans, Dr. Rogers, then a British army major, undertook a frighteningly difficult mission to set up centers for treating the partisan wounded in the wild mountainous countryside of Yugoslavia. The odds against success were staggering. The Germans hunted the doctors with fanatical skill, executed those who were caught alive. The Yugoslavs were poorly trained and badly equipped and at every turn Rogers was snared by Communistic red tape. It was an impossible job but he reports he did it.

Regulation and Mode of Action of Thyroid Harmones: A Ciba Foundation Symposium, by G. E. W. Wolstenholme, M. D. and E. C. P. Millar. ($8.50, *Little, Brown and Company, Boston 6, Mass.)* This is the 10th Colloquia on Endocrinology produced by these Symposia. During the last 15 years there has been an enormous activity in the field of thyroid investigation. This volume takes stock of the discoveries of this period by presenting formal papers by leading investigators the world over. These papers, and the informal discussions which follow them, serve as a clearing house of ideas on the latest concept of regulation of the thyroid gland on the one hand and the character and mode of its hormones on the other.

Brain Mechanisms and Drug Actions: A Symposium of the Houston Neurological Society, by William S. Fields. ($4.25, *Charles C. Thomas Publisher, Springfield, Ill.)* This is a timely subject because of the growing interest in it and this symposium gives us the present-day thinking on the subject which is now occupying the attention of internists, neurologists, psychiatrists and others interested in the manner tranquilizing drugs act on the nervous system.

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Social Security for Physicians . . .

Poll To Determine Opinions of OSMA Members To Be Conducted in October; Material Pro and Con on Subject To Be Carried in The Journal

AT THE 1958 Annual Meeting of the Ohio State Medical Association in Cincinnati, April 14-17, the House of Delegates adopted a resolution, calling for a poll of members on the question of whether or not physicians should be included in the Federal Social Security Program. It read as follows:

"WHEREAS, The inclusion of doctors of medicine in the Federal Social Security program is currently under consideration, and

"WHEREAS, The Ohio State Medical Association and the American Medical Association are now on record as opposing the inclusion of physicians in the Social Security program, and

"WHEREAS, A considerable number of physicians in Ohio have expressed a desire to be included in the Social Security program, and

"WHEREAS, It is desirable to ascertain the current sentiment of all members of the Ohio State Medical Association on this question,

"THEREFORE BE IT RESOLVED, That (1) the individual members of the Ohio State Medical Association be polled by the Association on the question as to whether they favor or oppose the inclusion of physicians in the Federal Social Security program, and (2) the results of this poll showing the number of votes in favor of and in opposition to such inclusion be made a matter of record and transmitted to the House of Delegates of the American Medical Association, and

"BE IT FURTHER RESOLVED, That such poll be conducted prior to the 1958 interim session of the American Medical Association so that the results of such poll can be submitted to the House of Delegates of the American Medical Association at said meeting."

The poll authorized by the House of Delegates will be conducted during the month of October.

Prior to that time, also by order of the House of Delegates, *The Journal* will present in each issue (July, August and September) selected material and comments, pro and con, on the subject of coverage of physicians under Social Security.

The first of the material which has been assembled appears in this article. Members who may have comments on this subject which they think would be of educational value to all members should send it to the Columbus Office where it will be reviewed and considered for publication.

Members should bear in mind that opinions expressed by the writers of the articles appearing in *The Journal* are solely the opinions of the authors and do not necessarily reflect the opinions of officials of the Ohio State Medical Association or staff members of *The Journal.*

Moreover, members should realize that some of the material being used was written several years ago. For that reason some of the figures may be out-dated. Nevertheless, the articles still are of value in this debate as they express basic opinions or present philosophical arguments on one side or the other.

* * *

Pro and Con Arguments

HERE are arguments, pro and con, on the question: Should the Old Age and Survivors Insurance provision of the Federal Social Security Act be amended to require the coverage of self-employed physicians?

The arguments appeared originally in the October, 1957, issue of *GP,* publication of the American Academy of General Practice, having been compiled by the Alabama Academy of General Practice after reviewing many articles, editorials and pamphlets on this subject. Referring to this the Alabama organization said: "The most pertinent arguments for and against social security for doctors as we see it are presented herewith. These arguments do not necessarily reflect the thinking of the author of this letter. They have been lifted in part or wholly from writings or statements of people who are considered experts on the subject. Every effort has been made to present these arguments in an unbiased manner."

Arguments For

The Philosophy of Social Security

A few words should be said about the philosophy of social security. On the heels of the

Arguments Against

Represents Creeping Socialism

Few would argue that the social security program arose from a real need in the early 1930's following

Arguments For (Cont'd)

depression in 1930, the "philosophy of federal concern for services and benefits traditionally discharged by states, communities, and individuals" began to develop. There was a growing conviction among many that federal unconcern for its citizens' problems is synonymous with national irresponsibility. Pressing needs created by economic crisis (e. g., the depression) cannot always be solved personally, regardless of the intention of the individual involved; there is a social and group character to the problem.

The quest for security and protection in old age or after death in an era of high costs, high taxes, declining earnings later in life, and general economic uncertainty is a legitimate one. Thus in 1935, the basic principle of using federal funds to advance the social security of all citizens won widespread popular support and has apparently become more popular with passing time.

President Eisenhower in his social security message of January, 1954, said that OASI developed in response to a need "arising from the complexities of our modern society." The system is not intended as a substitute for private savings, insurance plans and insurance protection. It is intended rather as a foundation upon which other forms of protection can be soundly built. Thus, the individual's own work, his planning and his thrift will bring him a higher standard of living upon his retirement, or his family a higher standard of living in the event of his death than would otherwise be the case. Hence the system both encourages thrift and helps to prevent destitution in our national life.

Compulsory Coverage or Nothing

Many doctors have expressed a desire for voluntary coverage under social security. This would seem to be out of the question because it is not actuarially sound and because Congress will not pass a bill giving this special privilege to self-employed doctors. Therefore, doctors either accept compulsory coverage or get nothing at all. Furthermore, it is unlikely that doctors will obtain a tax-deferment retirement program, as provided in the Jenkins-Keogh bill, until they are covered by compulsory social security.

Doctors Stand Alone in Opposition

All other organizations of self-employed professional people have endorsed the principle of compulsory coverage. Lawyers, who should certainly have a better understanding of the laws of

(Continued on Page 870)

Arguments Against (Cont'd)

the depression and has served and will continue to serve a useful function. However, since its inception, there seems to have been a change in political thinking. What was originally set up as a plan to provide a minimum of protection for the poor is now being extended into all phases of our country's social and economic body.

Again, few would argue that the federal government has a vital role to play in solving the problems of its citizens. However, too much substitution of individual responsibility by social or federal responsibility leads to a compromise of our independence and to a deterioration of the moral fiber of the nation.

There is little or no difference in the philosophy of compulsory old age and survivors insurance and the philosophy of compulsory health insurance. Doctors cannot divorce one from the other and accept the so-called "bargain rates" of social security for themselves and loudly deny the so-called "bargain rates" of socialized medicine to their neighbor's children who are in need of medical care. The entire concept of social security has as one of its basic features the socialization of health services. This has been proved by the course of social security legislation followed in European countries. As recently as 1947, legislation was proposed in the Congress of the United States to effect a compulsory health insurance program in this country. This legislation was largely formulated by the Social Security Administration at that time. Disability benefits enacted by Congress earlier this year in HR 7225 bring the Social Security Administration closer to the regulation of medical care.

Organized Medicine Favors Jenkins-Keogh Bills

Most physicians favor voluntary social security coverage but recognize the fact that such legislation is extremely unlikely. In preference to compulsory coverage, organized medicine is giving its active support to the Jenkins-Keogh bills. These bills would amend the Federal Internal Revenue Code so that self-employed physicians and others would have the same tax deferment advantages on the amounts set aside for retirement as are now enjoyed by officers and employees of corporations and associations, and others. A recent congressional poll indicates that this legislation has a good chance of passage this session.

Social Security Is Not Insurance

The OASI program is not really an "insurance" program as it is called. This was ruled by the

(Continued on Page 870)

Arguments For (Cont'd)

the land than their medical colleagues, have accepted the program. Life insurance underwriters have not objected to OASI; they must therefore consider it preferable in some respects to private insurance.

Private Insurance Companies Can't Offer Same Benefits

Private insurance companies can't administer a similar program at less expense. A doctor must pay $7,000 to $25,000 more than a dentist or lawyer pays for retirement and life insurance. The survivors of an individual covered by OASI stand to gain as much as $38,000, with a much more likely figure being $34,000, in the event of his death.

The pension for a dentist or lawyer approaching 65 and retirement may provide ridiculously high returns on investment. Using an extreme example, a man may obtain a pension for himself and his wife of $162.80 for a payment of only $189 in taxes over a 18-month period before retirement. There are special advantages for an individual who is entirely uninsurable or insurable only at high rates.

Arguments to the effect that private insurance companies offer programs comparable in cost and benefits to OASI do not consider the combined package representing the very considerable survivor protection and appreciable retirement program.

Some Doctors Stand to Lose OASI Credits

Many self-employed doctors have some OASI credits as a result of military service, teaching, previous salaried positions, etc. If these self-employed doctors are to continue to be excluded, these credits will be lost.

OASI Solvency May Require General Taxation

The question arises as to whether the whole social security system is actuarially unsound and hence may break down or not pay off in full. It seems fair to assume that if social security funds prove to be inadequate to pay the promised benefits, the deficiency will be made up out of general revenue. Since we must make up this extra revenue in the form of general taxes, perhaps we should share in the benefits which we are helping to finance.

(Continued on Page 872)

Arguments Against (Cont'd)

Supreme Court on May 24, 1937. This gimmick has been used to make the program saleable to the public. Could there be a better way to sell a paternalistic or socialistic scheme of compulsory taxation to traditionally independent people than to make its title and terminology synonymous in the people's minds with insurance, one of our oldest and most honored institutions? Insurance provides contractual rights. The Social Security Acts contains the following reservations of power: "The right to alter, amend, or repeal any provision of the act is hereby reserved to the Congress."

OASI, the Financial Frankenstein of the Century

The existence of the social security program, financially and politically unsound as it is, constitutes one of the greatest hazards of the century. By 1954, the social security accrued liability had reached the astounding figure of 280 billions dollars, equalling the debt that we have been able to build up in all other ways in the entire history of our country. There appears to be considerable doubt that this liability can be covered by existing social security tax laws.

Social Security Tax Dollar Poorly Protected

There is talk of the protection of the "insurance trust fund." The social security booklet states that "the reserve portion of the trust fund —that is, the part not required for current disbursement—is invested in interest bearing United States government securities." This means that the reserve portion is given by the government to the government in return for government bonds on which interest is to be paid into the "trust fund." This in turn means that the government must pay the government interest and principal in the future so that promised benefits can be paid. That part of the social security tax dollar, not immediately spent for benefits or administration, undoubtedly is used for other government expenses. This is not a way of putting money to work to earn more money. The principal way for this money to come back to the government is through general taxation.

Physicians Don't Want Federal Charity

Physicians as a group do not seek federal charity. Persons receiving OASI primary insurance benefits at the end of 1952 had already received on the average, or were to receive $24 for each fifty cents they had paid in taxes plus the fifty cents

(Continued on Page 872)



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Reference: *Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A.* **166**:*1019, March 1, 1958.*

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Arguments For (Cont'd)

Average Retirement Age of Men 68½-69 Years of Age

The argument is made that only one out of seven doctors retires between the ages of 65 and 72. This carries the implication that all other persons in the social security system retire promptly at the age 65 so that doctors would pay for the retirement costs of others. On the contrary, the average retirement age for men since the OASI system began has been between 68½ and 69.

Social Security Acceptance Won't Regiment the Profession

Compulsory coverage does not mean regimentation of the profession. Self-employed businessmen, who have been covered by OASI since 1951, have not experienced more regimentation than doctors during this time.

Carrying Principle Too Far

Social security is obviously here to stay. It is foolish for doctors to miss this "gravy train" ride merely for the sake of principle.

Social Security for Doctors Doesn't Mean More Government in Medicine

The inclusion or exclusion of physicians under OASI, while it is vitally important to us as individuals, cannot itself stimulate further government intrusion in the field of medicine.

Doctors Have a Social Obligation to Meet

If social security coverage were extended to all groups, several benefits to the system itself would flow from the very fact of completeness. This would tend to reduce the proportionate costs of benefits. Most important of all, complete coverage would in a matter of ten years or so reduce the need for public assistance to a bedrock minimum.

Physicians' Stand Important in Public Relations

Physicians alone oppose social security coverage. Is this likely to be regarded by the public as a conscientious effort on the part of a militant group of freedom-loving Americans bent upon thwarting a paternalistic government from further socializing the nation? Or, is it likely to be regarded as an effort by a well-heeled profession more concerned with its own selfish interests than with the interests of the nation as a whole? This could be important in our public relations.

Arguments Against (Cont'd)

paid by their employers. The amendments of 1954 boosted the ratio to at least $30 for each fifty cents. Thus, today 96 to 97 per cent of the pension is a gift to the senior citizens from the taxpayers. The argument that we should accept those windfall benefits because almost every eligible citizen will, has little appeal to physicians when their basic struggle is to preserve the free practice of medicine.

OASI Discriminates Against Higher Income Groups

Although retirement and survivor payments increase according to the amount of taxes paid, the program is weighted in favor of the low income groups. Furthermore, there is every indication that the tax base will be raised from the present $4,200, thereby creating an additional burden on the higher income groups. It has risen 40 per cent in five years; a proposal now before Congress would raise it to $4,800. Each physician might ask himself the following question: If I were a politician anxious to please the largest number of voters, would I favor raising the social security tax base figure so that more benefits could be promised?

Private Companies Offer Young Doctors Better Life Insurance

Advocates of compulsory coverage for physicians contend that self-employed physicians with young children could well afford to pay the entire social security tax for the sole purpose of obtaining survivorship benefits. Actually, equal or greater benefits can be purchased from life insurance companies at a lower cost. This can be done through decreasing term insurance (family income rider).

Only One in Seven Doctors Retires Before Age 75

Most self-employed physicians do not retire. Currently about six physicians out of seven in the age group 65-75 are engaged in the active practice of medicine. Thus, the provisions of the OASI relative to retirement simply do not fit the economic pattern of the self-employed physician.

Government Responsibility Synonymous with Individual Irresponsibility

Those favoring social security contend that "the purposes are so worthwhile that we as doctors and humanitarians should back them. They say that social responsibility is part of civilization and that

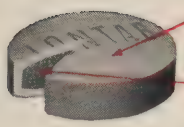
(Continued on Page 874)

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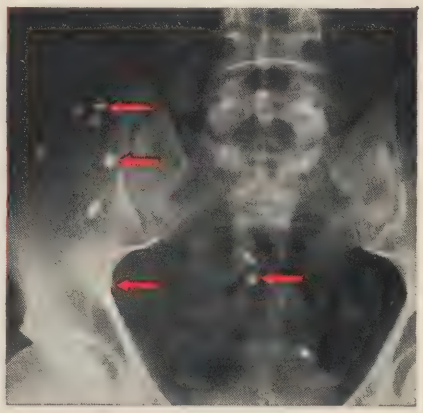
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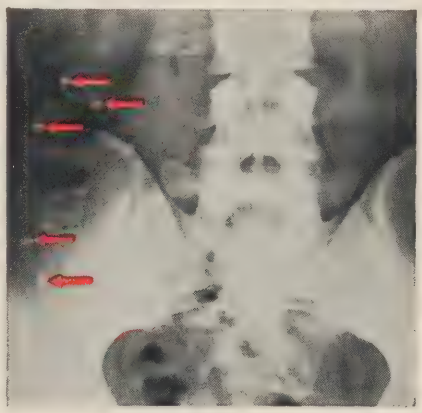
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8 hours Lontabs are still visible as substance of core continues to be released.



Arguments Against (Cont'd)

it should increase. Unfortunately in the history of civilization, social (or government in their minds) responsibility has always been synonymous with individual irresponsibility. As the latter grows, economics and civilizations decline and die, or are killed. Those who wish to be "humanitarians" actually have the greatest stakes in keeping social security sound. The self-employed physicians have nothing to be ashamed of in relation to their dollar contribution to humanity at large.

When we see the 'humanitarians' always so ready to give generously of the time, talent, training, energies and incomes of others, making contributions of comparable value to society, then we will listen with more sympathetic, but not less critical ears, to their Utopia—you to pay!—schemes and dreams.

Compulsory Social Security Advocated by Physicians Forum

Most doctors have recently received literature advocating compulsory social security from a group known as the Committee on Social Security for Doctors of the Physicians Forum. The source of this material should immediately cast doubt on the accuracy and objectivity of its message. Most physicians will recall that the Physicians Forum was the only medical organization in the country that supported national compulsory health insurance and will not look kindly on any cause that it supports.

* * *

Analysis by Insurance Man

"MAJOR Issues in the Proposed Coverage of Physicians Under Social Security" was the subject of an address by Benjamin B. Kendrick before the Providence Medical Association, Providence, R. I., on January 7, 1957. Mr. Kendrick of New York City is research associate of the Life Insurance Association of America and editor of the magazine *American Economic Security*. He was formerly Social Security analyst of the United States Chamber of Commerce. The text of his address follows:

This coverage question is quite an important one. If physicians should be brought under the old-age and survivors insurance provisions of the social security legislation—the so-called OASI system—a beginning doctor could anticipate paying social security taxes of up to about $10,000 in the course of a lifetime of practice—and this figure is based on the unlikely assumption that the OASI system will not be further liberalized during his lifetime. When possible liberalizations in the system are taken into account, the physician's lifetime taxes might run a great deal higher. Roughly offsetting these taxes, of course, are the social security benefit expectancies he would gain.

More important than the dollars and cents of it may be some other questions involved. For instance, would the medical profession be able to speak more effectively in Washington on matters relating to social security, if inside or outside the OASI system? Again, is there any right or wrong to the coverage proposal from a standpoint of principle?

Because of the importance of the issues, it is good that the medical profession is devoting increasing attention to the proposal for social security coverage. Let me say, too, that if doctors should decide to seek OASI coverage, they had better be very sure they have reached the right decision—because once under the OASI system, it is most unlikely they would ever have a chance to withdraw.

The Physicians Must Decide

It is of course the responsibility of Congress, in its wisdom, to enact and amend the Federal social security laws. However, Congress has never yet extended OASI coverage to any considerable group of people without evidence that the members of the group preponderantly wanted to be under OASI. If spokesmen for the medical profession should tell Congress that doctors want OASI coverage, they would surely acquire it shortly thereafter. Conversely, if medical spokesmen continue to tell Congress that doctors do not want OASI coverage, then I have no doubt that physicians can remain outside the system—at least for some time to come.

Thus, it seems to me, doctors must decide for themselves whether they want to be in or out of OASI. It would certainly be presumptuous of me —or of any other layman—to try to tell the members of the medical profession what they ought to do. What I may be able to contribute tonight is to furnish some relevant information, and some informed guesses, that may assist those present in arriving at their own conclusions.

Voluntary OASI Coverage for Physicians Unlikely

In advance of this meeting, Mr. Farrell thoughtfully sent me a copy of the May 1955 report on the Rhode Island Medical Society's membership poll

(Continued on Page 876)



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Social Security for Physicians (Cont'd.)

as to physician participation in the OASI system. As you know, the report showed that, while the vast majority of the members responding were opposed to compulsory OASI coverage, voluntary coverage for those wishing it was favored by a good majority.

However, there are a number of objections to voluntary OASI coverage for doctors—or for any other group—and I think Congress is well aware of them. The chief argument against voluntary coverage concerns the so-called *adverse selection* involved. In other words, the thought is that those whose prospective benefits stood to be greater than their prospective taxes would tend to choose to be in the system, whereas those whose taxes stood to exceed their benefits would tend to stay out. To the extent these tendencies operated, the voluntary participants would make a *profit* on their coverage. Moreover, assuming the system continues to be run on a self-supporting basis, any profit made by voluntary participants must necessarily be at the long-run expense of the others under OASI, who are almost all covered on a compulsory basis.

Another objection to voluntary coverage relates to what most people agree on as being the system's fundamental purpose—that of furnishing a basic floor of protection for all against want. The argument runs that, under voluntary provisions, those most likely to need the benefits would be the least likely to elect coverage, whereas those least likely to be in need would be the most likely to elect coverage. Perhaps this argument is not entirely applicable to physicians, but certainly there is at least some merit in it.

A third argument is that a governmental program like OASI, dealing with tens of millions of people over scores of years, must be kept relatively simple if it is not to bog down through administrative complexities and costs in sheer bureaucratic weight. And voluntary provisions do mean a great deal of extra complexity that I perhaps need not take the time to spell out.

For these reasons, it seems unlikely that Congress would offer physicians, on an individual basis, the right to accept or reject OASI coverage. I think the actual choice will prove to be between no coverage for any and compulsory coverage for all.

Employed Physicians Already Covered

In saying "no coverage for any," I am of course referring to self-employed physicians. Doctors

(Continued on Page 878)

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Social Security for Physicians (Cont'd.)

employed on a salary, as no doubt you know, are now covered by OASI (and have been since the system's inception), if the employment area itself is inside the system's purview.

Perhaps you are not aware of the extent to which physicians already have OASI coverage. I have some figures on this, based on a sample survey made by the OASI Bureau of the Social Security Administration in 1955.

According to that survey, 45 per cent of the 201,000 physicians listed in the A. M. A. directory had at least some credited earnings under OASI. And 22 per cent of the physicians listed had enough OASI coverage to have a so-called *fully insured* status under the system or to have had such a status at some previous time.

The sample survey, also, studied separately the listed physicians who were in self-employment (presumably private practice in most cases) at the time the survey was made. Such physicians, of course, could have acquired OASI wage credits either before entering private practice or by part-time employment while in private practice. At any rate, of the self-employed physicians, 35 per cent had at least some covered earnings, while 11 per cent had or had had a *fully insured* status.

These figures have probably gone up somewhat since the survey was made. The main reason for thinking so is that there have been several bits of new legislation since then, extending the area of OASI coverage, and hence increasing the proportion of salaried physicians who are covered.

In this regard, let me call your attention to some new legislation extending regular OASI coverage, beginning January 1, 1957, to members of the armed forces. There are also gratuitous OASI wage credits provided for military service between September 15, 1940, and December 31, 1956. Both sets of provisions are fully applicable to service in the uniformed forces in any medical capacity.

I know personally of one case where these provisions have already proven effective. There is a lady employed in our office whose husband had been a physician before his death about two years ago. He had never been under the regular OASI provisions, had never paid a cent in social security taxes, and in fact, did not even have a social security number. However, he had served for about four years in the armed forces during the war. As a result, his widow and four children together have been drawing $66.40 a month in OASI benefits.

The general point I am trying to make is that physicians have a surprisingly large amount of OASI coverage already. The proposal we are discussing can hence be restated as being whether doctors wish OASI coverage for private practice to go with the coverage they already have in salaried employment and during periods of military service.

How Would Doctors Make Out Compared With Others Under OASI?

Let me now turn to the question of whether doctors would get their money's worth out of the OASI system if they were covered under it. This question can best be handled as two separate questions: First, how would doctors make out compared with the general population under OASI? And second, how does the covered population, on an average, make out under OASI? These questions, let me emphasize, relate to compulsory coverage; I have already suggested that physicians would stand to get a good deal more than their money's worth out of the system if they were to have coverage on an optional basis.

No mathematical answer is possible to either of the two questions on compulsory coverage. This is mainly because OASI does not stand still; no one really knows what the system will come to be like in the future. However, I think the questions on how doctors would make out can be answered fairly well—but in non-mathematical terms.

Compared with other people compulsorily covered by OASI, doctors would be better off in one major way, and worse off in another. Doctors would be better off than most others in that, as self-employed persons, they would pay only three-quarters of the combined employer-employee taxes applying to people in covered employment. At the ultimate tax rates, applicable in 1975 and thereafter under the present tax-rate schedule, the self-employed will pay 6⅜ per cent in contrast with a combined 8½ per cent on employment earnings.

On the other hand, the OASI benefit formula is geared to favor those at the low end of the earnings' scale. Because physicians tend to be near the high end of the scale, this means that the benefit formula is geared to their disadvantage. But the 25 per cent discount that doctors would get on their tax bill may roughly cancel the fact that the benefit formula would be loaded against them.

There are various other minor points about how physicians would fare under OASI, compared with others under the system, of which perhaps only one is worth mentioning. I have frequently heard it argued that doctors would lose out because they do not normally retire at age sixty-five but continue their practices indefinitely. Hence, it is argued, physicians could not draw OASI retirement

(Continued on Page 880)

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Social Security for Physicians (Cont'd.)

benefits because the so-called *work clause* would operate to prevent it.

In my best judgment, there is little real substance to this argument. For one thing, most laymen likewise do not retire at age sixty-five. The statistics show that, so far, the average age at retirement under OASI has been about sixty-nine. Moreover, there is a provision in the OASI legislation that the so-called *work clause* ceases to apply at age seventy-two. And it is not at all far-fetched to think that Congress may reduce this age at which benefits become payable regardless of earnings to seventy.

So, all things considered, I think doctors would make out about as well under compulsory OASI coverage as do people generally.

How Do People Generally Make Out Under OASI?

But does the covered population generally get its money's worth from OASI? On the whole, I think so—but I am speaking now only about the existing system, and not about what it may come to be in the future.

In any event, the aggregate of benefit payments under the system does not differ greatly from the aggregate of tax receipts. Some of the past tax receipts have been used to build up a relatively small reserve fund, which is still increasing slowly. This fund earns interest, which adds to the amounts available for benefits. On the other hand, administrative expenses are paid out of the fund. Concerning administrative expenses, I may say that the OASI program is a huge, mass-production type of operation, and as a result, the administrative costs run only about 2 per cent of the sums taken in or paid out.

In contrast to an insurance company, OASI pays no taxes and employs no salesmen. On the other hand, the interest earnings of OASI are quite small, relatively speaking. This is mainly because the system has operated on nearly a pay-as-you-go basis, and consequently, the reserve fund represents only a small fraction of the accrued liabilities. Also, the funds are invested in Government bonds, which bear a relatively low interest rate.

Of course, there is much more to it than these brief comments indicate. An insurance company guarantees its policy benefits; OASI benefits, on the other hand, are subject to change—or even discontinuance—at the will of Congress, as Section 1104 of the amended Social Security Act explicitly provides. Also, loans can be had against insurance-policy reserves; in OASI there are no loan provisions.

More important, insurance companies offer numerous policies from which the purchaser can carefully select the one best meeting his needs, desires, and premium-paying ability. In OASI, by contrast, there is no choice: One set of benefit and tax provisions applies, willy-nilly, to all.

Perhaps this last point is the heart of the matter. As a social benefit program, designed to meet the minimum needs for protection of the population generally, OASI can be considered a *good buy,* with the participants, on the whole, truly getting their money's worth. However, if OASI should be over-expanded, and attempt to provide full protection for the population, then participants will no longer be getting their money's worth because their taxes will be buying benefits differing, more or less, from what they need, want, and are willing to pay for. And no misfit article, that you are required to use, can be a good buy regardless of the price.

Questions of Principle and Philosophy

More important than the dollars and cents of doctors' coverage under OASI may be questions of principle or philosophy, as I suggested earlier. The trouble is that some people—using one line of argument—arrive at the conclusion physicians certainly should be covered, while others—using another line of argument—conclude that they certainly should not be.

People such as some of my former colleagues at the Social Security Board argue that OASI is designed to furnish universal protection, that the system cannot work with maximum efficiency so long as any important group remains outside it, and that consequently physicians should be brought under the general law. My own feeling is that, while there is some validity to this argument, universal coverage is not really essential. Also, I think it is proper—and in accord with democratic principles—for Congress to take the wishes of the group affected into account.

The opposing view, briefly, is that social security is a step on the road to socialism and worse—and that the medical profession should consequently oppose coverage with vigor. My own feeling is that, while future history might verify the first part of this argument, the second part does not follow. In other words, if broad forces are leading the United States to socialism, the trend could hardly be affected much by the action of physicians on OASI coverage.

All in all, I am personally not convinced that there are over-riding considerations of philosophy

(Continued on Page 882)



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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

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Social Security for Physicians (Cont'd.)

or principle either way. Consequently, if I were a physician, I think I would view the question mainly from an economic standpoint, making the best guess I could as to what changes in OASI the future is likely to bring.

Future Changes in OASI

And that leads us to the $64 billion question—how will OASI be shaped in the future? Will the system be over-expanded?

It could happen. Surely Congress will be subject to continual pressure for OASI liberalization —higher benefits, more lenient eligibility requirements, new types of benefits. And it can scarcely be doubted that some liberalizations will be enacted from time to time.

Nevertheless, I am cautiously optimistic that the pressure for continual OASI expansion can be contained fairly well within reasonable bounds. The chief thing that makes me think so is the growing evidence that the repeatedly increased OASI payroll taxes are beginning to become high enough and painful enough to encourage voters to carefully scrutinize all proposals to expand benefits.

During consideration of the bill which became the 1956 Social Security Amendments, Congressmen seemed very conscious of the tax angle. The original bill had provided full benefits for women at age sixty-two, instead of sixty-five, but this provision in conjunction with the new cash disability benefit provisions would have cost employers and employees a tax increase of one per cent of payroll. To avoid such a tax increase, reduced benefits for wives and working women below sixty-five were substituted, with the tax increase being held to one-half of one per cent.

Moreover, it is important to remember that existing law provides a whole schedule of tax increases to take effect between now and 1975. And these tax increases, of course, are required merely to meet the growing costs of the present benefit provisions—they cannot be used to provide additional benefits. When the American people have had to meet the first one or two of these scheduled tax increases, with no corresponding increase in benefits, they will be even less willing than at present to pay still higher taxes for new liberalizations in the benefit provisions.

Possible OASI Liberalizations Affecting Medical Practice

What possible liberalizations in OASI would affect the practice of medicine? Let me devote just a minute or two to this question.

To begin with, as you know, the new cash disability benefit provisions in the 1956 Amendments do affect medical practice. The doctor's role is to make examinations and certifications as to apparently disabling impairments, subject to some supervision from the social security authorities.

There will surely be intense pressure for expansion of these new provisions. Under present legislation, the benefits are available only at age fifty and over, but demands are already heard that they be provided regardless of age.

Moreover, there are no benefits for the wives and children of disability beneficiaries under the new provisions, whereas dependents' benefits are provided under OASI in case of retirement or death. Dependents' benefits in disability cases are sure to be urged.

Also, the 1956 Amendments provide benefits for disabled children. You see, there are two separate things: Benefits for the able-bodied dependents of disabled people, and benefits for the disabled dependents of people who are dead or retired, but not disabled. In any event, the new principle of benefits for disabled dependents could conceivably be carried much further.

Now as to the possibilities for Federal medical-care benefits—that is, socialized medicine—either inside or outside the OASI system. It seems clear that the direct threat of such legislation has largely evaporated. And I think much of the credit is due to the phenomenal growth of voluntary health insurance—both in numbers covered and in the breadth and depth of their protection. Here I think the insurance companies—along with Blue Cross and Blue Shield—are entitled to take a bow.

The Achilles heel in the body of voluntary health insurance may be in the limited extent to which the retired aged are protected. There seem to be growing demands that OASI be expanded to include medical-care benefits for old-age beneficiaries. Incidentally, this proposal is not new; you may recall that Oscar Ewing was urging the same general plan when he was Federal Security Administrator.

If the past is any guide, it seems likely that voluntary health insurance will solve the problem of providing more adequate protection for the retired aged. In particular, there are encouraging new developments in adding group health insurance protection for retired employees to employer and union welfare programs.

However, voluntary health insurance cannot do the entire job over night. The new policies mainly give protection in retirement to employees now active. For a temporary period, there will continue to be a partial vacancy—enticing to the proponents

(Continued on Page 884)

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1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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Social Security for Physicians (Cont'd.)

of compulsory health insurance. If their noses should enter the tent, a general socialized medicine program might follow.

Could the Profession Speak Best Inside or Outside of OASI?

This foreboding possibility leads to a question I raised at the outset—would the medical profession be able to speak more effectively in Washington on social security matters, if inside or outside the OASI system? As I see it, there are three answers to this question, depending on the type of matter being considered.

If this issue is one affecting the practice of medicine—such as a proposal to add more disability benefits or some medical-care benefits to OASI—then doctors are qualified to testify as experts. On such an issue, I think it would make little if any difference whether the doctors were themselves covered by the system.

If the issue is a general social security one, not affecting the practice of medicine, then it seems to me, doctors would have little reason to testify, and little weight if they did, unless they were themselves covered by OASI. I can imagine a Congressman thinking: "What business is it of the doctors to concern themselves with a proposed increase in social security taxes and benefits, if they are themselves outside the system?"

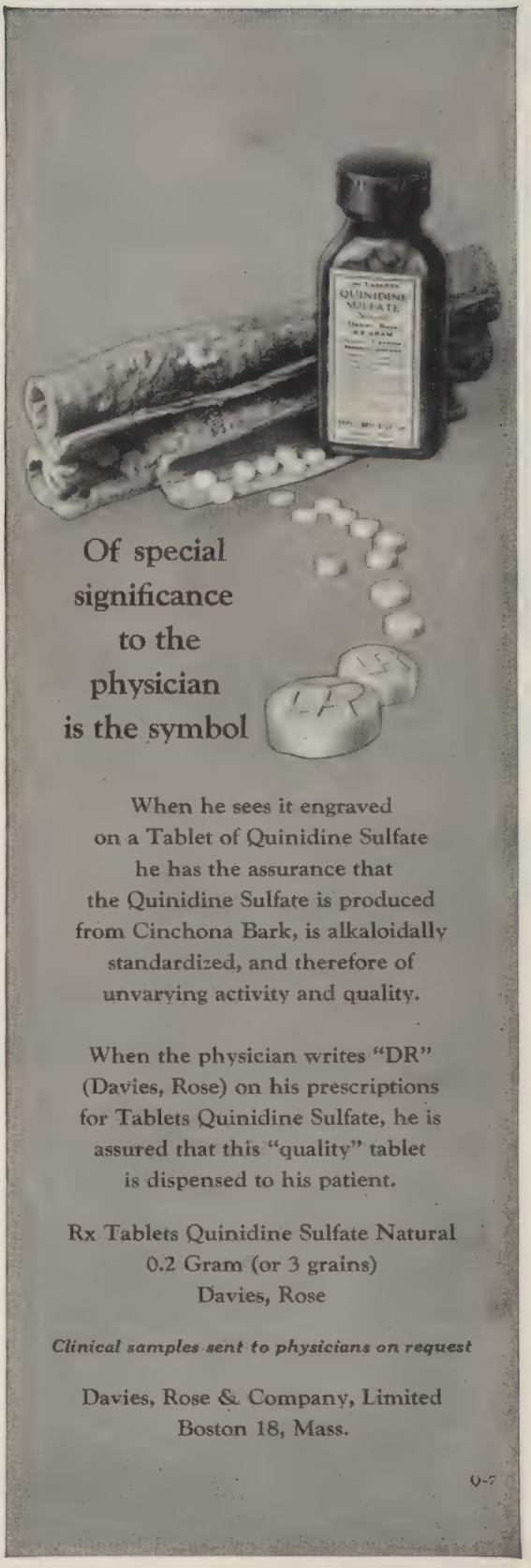
The third kind of issue I have in mind is the sort posed by the so-called Jenkins-Keogh Bill. This proposal is one to give favorable income-tax treatment to sums set aside for their retirement by doctors and by other self-employed people. Here I can imagine a Congressman asking: "Why should we give doctors this special tax treatment, when they are unwilling to come under the general retirement system Congress has set up?"

Conclusion

Well, I have finished outlining what seem to me to be the major issues raised by the proposed OASI coverage of physicians. And I have indicated my own thoughts about each.

In conclusion, I must confess it all adds up to nearly nothing—in other words, that the *cons* just about balance the *pros*. Perhaps, as I see it, there is a bit more to be said in favor of OASI coverage for doctors than against it. However, the difference is not great. And, depending on the relative importance one attaches to the various points, he could easily reach the opposite conclusion.

Gentlemen, it is your decision. It is your views which will decide the question, not mine. Thank you.



You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Dr. Gunnar Gundersen—112th President

In taking the oath of office as 112th president of the American Medical Association June 24 in San Francisco, Dr. Gunnar Gundersen called attention to the physician's obligations on the international scene. The 61-year-old LaCrosse, Wis., surgeon said: "As both physicians and citizens, we must see that medicine plays its full role, not only in promoting better world health, but also in helping the search for brotherhood and peace."

As American citizens, Dr. Gundersen said, "our first duty is to this country. But as members of the brotherhood of man, we also have a duty toward all men who yearn for freedom, dignity and peace." He further pointed out that "medicine can play a vitally effective part in bringing reality to the dream of world peace. For medicine, despite the designs of politicians or dictators, is above the harsh conflicts of ideologies and power policies. Medicine, like religion, speaks a universal language which passes all barriers of race, creed, color and nationality."

Meeting on Chemical Products

The AMA's Committee on Toxicology will conduct a meeting July 25 at AMA Headquarters in Chicago to discuss proposed legislation requiring the declaration of hazardous ingredients and warning statements on the label and in the accompanying literature of household, commercial and industrial chemical products. Representatives of interested industries and trade associations also will attend. Further information may be secured from the Committee.

New Exhibit on Fitness

"Seven Paths to Fitness" is the title of a new American Medical Association exhibit slated for debut at the Public Relations Institute August 27-28 in Chicago. Sponsored by the Bureau of Health Education in cooperation with the Bureau of Exhibits, the new display emphasizes the following seven avenues to health and fitness: Nutrition, relaxation, play, exercise, dental care, medical care and work. Over-all murals depict the sources and activities in each category. The exhibit is primarily intended for professional audiences such as physicians, educators and others having a direct interest in physical fitness. It will be available for bookings after September 1 through the Bureau of Exhibits. A smaller type exhibit on the same subject will be completed later.

Sets August 27-28 For PR Institute

Be sure to circle the dates of Wednesday and Thursday, August 27 and 28, on your calendar for the American Medical Association's 1958 Public Relations Institute at the Drake Hotel, Chicago. The meeting will be of particular interest to state and county medical society executives, public relations personnel and public relations chairmen. Further details will be announced later.

Films of AMA Annual Meeting

Filmed highlights of the AMA's 107th Annual Meeting—presented by the American Medical Association in cooperation with Merck, Sharp & Dohme—will be available after September 1 for showing to medical meetings. Entitled "San Francisco—1958" (TV Abstracts of the AMA Annual Meeting), the 40-minute black and white films taken from kinescopes of five daily television programs may be secured either from the AMA Film Library or Merck, Sharp & Dohme, Philadelphia 1, Penna. These programs will feature interviews with speakers on the convention program.

New Films Added

Two more film subjects from the fracture series produced for the Veterans Administration have been added to the AMA film library. "Fractures about the Knee" was reviewed in the *AMA Journal,* Jan. 26, 1957, page 308. These two basic teaching films on fractures incorporate diagrammatic illustrations and excellent photography.

A highly recommended teaching film from the Mayo Clinic also has been added to the film library. "Technique of Proctoscopy" was the subject of an illustrated film review appearing in the *AMA Journal,* March 22, 1958, page 1510. This film is a portrayal, step by step, from the taking of the proctologic history to the completion of the proctosigmoidoscopic examination.

High School Scientists Exhibit

The American Medical Association was host to two teen-age scientists during its Annual Meeting in San Francisco. As a result of their winning the AMA's top citations at the National Science Fair in Flint, Mich., May 7-10, Clare L. Chatland, 16, Missoula, Mont., and David R. Brown, 15, Minneapolis, Minn., showed their exhibits to 30,000 physicians and guests at the San Francisco meeting.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WORKSHOP SHOWS IMPORTANCE OF DOCTOR-WRITER COOPERATION

Cooperation between the physician and the news media writer pays dividends. This was vividly brought out at the Medical Writing Workshop conducted jointly by the AMA and National Association of Science Writers, May 22, in Cincinnati.

The science writers and the physicians readily agreed that this cooperation has produced accurate and informative medical news written in lay terms for lay consumption. It has helped to give the laymen a better understanding of the physician and the medical profession.

Physicians have learned that reporters in almost every instance are anxious to write accurately and appreciate the assistance they can obtain from the medical profession. Reporters also have learned that medical men want to check their reports not for editing or censorship, but rather to make certain that nothing has gone astray in the transition from medical terminology to lay reading.

Since only a few Ohio newspapers have full-time science writers, most physicians in the state find themselves confronted with general reporters with not much experience in the science news field.

In our opinion, it is in the best interests of the physician and his profession to befriend, cooperate with and assist these reporters. The end results are well worth the effort.

SAVE JUDICIAL COUNCIL OPINIONS FOR REFERENCE

The principles of Medical Ethics and Opinions and Reports of the Judicial Council, abstracted and annotated, were published in a special edition of the June 7 issue of the *AMA Journal*.

For the first time in the Association's history, opinions and reports of the Judicial Council interpreting the Principles of Medical Ethics have been assembled and made available to all members of the Association. Not only does this compilation include interpretations of the Principles by the Council but it also includes the several sections of the 1955 edition of the Principles.

This was thought desirable in order to preserve the language used in the past to express ethical concepts. It serves also to emphasize that the short (1957) version of the Principles does contain the spirit and intent of previous, longer versions.

This document should be valuable to all physicians and especially to those whose duties include serving on boards of censors or similar committees. Every physician should become familiar with the contents of this document and preserve it for future reference.

CLYDE CUMMER MADE MANY CONTRIBUTIONS

Many within and outside the medical profession were saddened to learn of the death of Dr. Clyde L. Cummer, Cleveland, who served as President of the Ohio State Medical Association in 1933-34.

Dr. Cummer was outstanding among the long list of distinguished leaders of the Association.

In addition to being a great scholar, fine teacher, and expert in his chosen specialty, Dr. Cummer was almost a genius in organization activities. He not only knew how to organize for an event or project but he possessed the know-how and follow-through needed to get the job done. The many honors which he received over the years from professional and non-professional groups are testimonials to his efficiency and the respect which others had for his initiative and rare abilities.

Add to these attributes, the fact that Clyde Cummer was the finest of gentlemen—one who never found it too much trouble to do a good turn for a friend or for any one of the medical societies to which he belonged.

Dr. Cummer's contributions were many. Because of him, many, including the organizations to which he devoted much time and effort, have richly benefitted.

"VITAL POLIO PROGRAM"— AN EXCELLENT EDITORIAL

In our opinion an editorial entitled "Vital Polio Program" published on May 5 by the *Youngstown Vindicator* contains a carload of common sense. It is an exceedingly realistic, as well as sound, observation on the controversy as to how a polio immunization program should be handled. It lends strong support to the basic policy of the Ohio State Medical Association on this subject—a policy concurred in by most of the county medical societies of the state, including the Mahoning County Medical Society.

The editorial is lengthy. Nevertheless, because of its importance it is reproduced here with the hope that medical societies in other counties may

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Prompt 4 way check of diarrhea



- Curbs excessive peristalsis
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DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz.*
Exempt Narcotic. Available on Prescription Only.

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be able to use its content to advantage in their public relations. Said the *Vindicator:*

"The precise method to be used in providing immunization against polio is not the most important part of the program. Certain procedures must be followed, of course, but the first consideration should be the elimination of unnecessary delays, plus positive action to establish and maintain an effective inoculation campaign, the end of which is not now in sight.

"In many cases, parents or heads of family groups are accepting responsibility in the health program instead of allowing schools or other agencies to shoulder the entire burden. It's hard to see why this practice is not general, considering the fact that so much is at stake. Preventive action is much simpler, and far less expensive, than rehabilitation.

"Basically, this is the kind of program which the Mahoning County Medical Society approves. The society has been trying to impress upon everyone 40 years of age or under the importance of considering polio immunization as a personal matter which demands some initiative on the part of the individual.

The physicians have no quarrel with the fundamental idea in mass inoculations in the schools. However, they fear that this plan may tend to produce in the public mind a false sense of security, with the result that less attention would be given to immunization, which is equally important, among pre-school children and adults under 40 years of age. Parents, they say, may be inclined to delay inoculation of children of preschool age on the doubtful assumption that the vaccine would always be available in the schools. Even if it is, who is to guarantee the child's health until that stage?

"The Medical Society is considering sending a letter to the parents of all school children in the county, including public, parochial and county schools, inviting them to receive the polio shots in their doctors' offices. This seems to be worthwhile because it will bring together doctor and parents for a personal discussion of each child's health problems and both the doctor and the family will be better satisfied.

"In order to be successful, the plan must have the cooperation of parents themselves, health authorities and the schools. There is no question about school cooperation; and health officials would certainly go along with the program. Any lack of family cooperation would be unthinkable.

"Much has been said about the fact that school inoculations would be free. This is a fact, but it is also true that the vaccine would be provided free in doctors' offices if there were a doubt as to ability to pay. Physicians probably have already given away more vaccine than they have been paid for.

"As Medical Society officers explain, the polio campaign is not based on economics; it is intended as an education in health. A few simple facts stand out: The need for immunization is undeniable; there is an abundance of vaccine; it will be given free, and willingly, where needed. Whatever plan is followed—mass inoculations in the schools, or in the doctors' offices—the results are bound to be good as long as the coverage is thorough."

BIG ENOUGH TO GIVE ALL, BIG ENOUGH TO TAKE ALL

Heard Dr. Allman, president of the AMA, hand out this quickie the other day:

"Any government that gets big enough to give everyone everything they want will be big enough to take away from them everything they've got."

Makes a lot of sense, doesn't it?

Quote it to the next chap—maybe a physician—when he starts advocating that government should do this or that—with its money (the taxpayers' money, of course).

DOCTOR HAS BIG STAKE IN HIGHWAY SAFETY

Highway safety is an ever-present concern for many physicians in Ohio.

The House of Delegates of the OSMA apparently agrees. At the recent Cincinnati meeting it endorsed a proposal to bring about highway safety in Ohio and authorized President Woodhouse to name a special committee for this purpose.

Many doctors are doing their part along with other citizens of their communities by participating in local safety programs and by working with organizations concerned with this problem. Much more needs to be done.

Citizens are likely to be lulled into complacency by the ever-present toll of traffic accidents. Although perhaps not expressed, the attitude often is: "It's not much greater than it was a year ago."

Highway Safety Director Gordon Jeffery pointed up the toll recently when he compared the total for a year with the populations of certain communities. If the entire population of a town of 2,000 were wiped out in a year's time, people would take notice. Yet that is less than the number of deaths in Ohio during 1957 from traffic accidents, and people do not take notice.

If the entire population of a city the size of Springfield (more than 78,000) were injured in a catastrophy, the entire population of the state would take steps to prevent a recurrence. Yet more than that number were injured in traffic accidents in the state last year.

Physicians are not exempt. A quick scan of doctors' deaths during 1957 shows that at least four Ohio physicians died as a direct result of traffic accidents.

Perhaps the answer is one of the well-known



when eating moves outdoors . . .

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three E's—education, enforcement, engineering. Perhaps there is another answer. But whatever the solution to so great a problem, it behooves every doctor to study the problem and offer his services in whatever capacity he believes most fitting.

All members will be called upon for cooperation by the new committee as soon as it gets its program underway.

ACTIVITY OF AUXILIARY DRAWS DESERVED PRAISE

A recent tea which the Ottawa County Medical Society Auxiliary gave for some 100 girls from three high schools has drawn editorial praise of a Port Clinton newspaper.

The tea was arranged in order to draw to the attention of the high school girls the need for registered and practical nurses, dietitians and medical technicians.

Many county auxiliaries throughout the state are actively engaged in this same pursuit. This not only helps to provide future members of these allied professions but also demonstrates clearly that these fields have the interest and well wishes of the medical profession.

TO GIVE OR NOT TO GIVE, THE RECORDS

It's not uncommon for a physician to have one of his patients ask him for a copy of the records in his case. What should the physician do? What are the ethical and public relations angles? Here's what the Judicial Council of the AMA had to say on this question:

The principles of medical ethics do not intend or require that a physician give a copy of his records to his patient, the council believes. These records are primarily the physician's own notes compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment. The records are medical and technical, personal and often informal. Standing alone they are meaningless to the patient but of value to the physician and perhaps to a succeeding physician.

The patient, however, or one responsible for him, is entitled to know the nature of the illness and the general course or regimen of therapy employed by his physician. The extent to which the physician must advise his patient may be limited by the nature of the illness and the character of the patient. The physician in advising his patient must always act as he would wish to be treated were he in a like situation.

Cook County Graduate School of Medicine

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STARTING DATES—FALL, 1958

SURGERY—Surgical Technic, two weeks, Aug. 18, Sept. 15. Surgery of Colon and Rectum, one week, Sept. 22, Oct. 27. Basic Principles in General Surgery, two weeks, Oct. 13. Esophageal Surgery, one week, Sept. 15. Thoracic Surgery, one week, Sept. 22. Gallbladder Surgery, three days, Nov. 3. Surgery of Hernia, three days, Nov. 6. General Surgery, two weeks, Nov. 10; one week, Oct. 27. Fractures & Traumatic Surgery, two weeks, Oct. 20. Treatment of Varicose Veins, two days, Sept. 15. American Board Review Course, two weeks, Nov. 10. Blood Vessel Surgery, one week, Oct. 20.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 8. Vaginal Approach to Pelvic Surgery, one week, Oct. 6. General & Surgical Obstetrics, two weeks, Sept. 22.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3. American Board Review Course, one week, Sept. 29, (for Part I Candidates only).

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 22. Clinical Uses of Radioisotopes, two weeks, Sept. 29.

UROLOGY—Two-week intensive course, Oct. 13. Ten-day practical course in Cystoscopy by appointment.

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

AMA has told official Washington that a strengthened Federal civil defense program should include maintaining at top level health and medical functions of Federal Civil Defense Administration and Office of Defense Mobilization.

* * *

President Eisenhower has appealed for greater use of Salk polio vaccine, following a report to him made jointly by PHS and NFIP that "among the 111 million persons under 40 years, only 49 million have received the full course of three injections, and 46.5 million have received none."

* * *

National Heart Institute reports two of its researchers have found that instead of stimulating the heart as it ordinarily does, adrenalin when used in combination with digitalis depresses the heart and body temperatures are lowered by hypothermia.

* * *

American Association of Medical Colleges has reported that the nation's 85 medical schools will require $275 million for rehabilitation and new construction in the next few years; about $25 million is needed for rehabilitation. This total does not include research and hospital construction. Recent AAMC survey showed that meeting these needs would enable the schools to graduate an additional 1,000 physicians yearly, bringing total yearly graduates to 8,000.

* * *

New chief of PHS Bureau of Medical Services is Dr. James V. Lowry, upped from deputy chief following the March 26 death of native Ohioan Dr. John W. Cronin. Position carries the rank of assistant surgeon general.

* * *

First quarter of 1958 saw Federal government donate surplus property, for which it had paid $81,919,998, to the states for free distribution among public health, civil defense and educational activities. Every state and territory received some surplus.

* * *

Public Health Service reports that in last six months of 1957, 24,953,000 persons suffered injuries requiring medical attention and limiting their activities for at least one day. Forty per cent were involved in home accidents, 10 per cent in motor vehicle and 16 per cent in occupational accidents. Nearly 60 per cent were males; nearly 60 per cent were urban residents.

* * *

Meeting recently in Washington, National Academy of Sciences included Dr. John Holmes Dingle, professor of preventive medicine at Western Reserve University School of Medicine among the 30 new persons elected to membership in the Academy.

* * *

Internal Revenue Service has ruled that physicians in full-time employ of hospitals may exclude from income payments patients make to those physicians so long as the checks are endorsed over to the hospital. However, tax return schedules must show such sources, amounts received and disposition made.

* * *

Federal Trade Commission has ordered Bishop Hair Experts, of Cincinnati, to desist in making certain claims for its products. Order followed testimony by three dermatologists alleging the claims were false.

* * *

Food and Drug Administration reports its agents hard put to keep up with increasing complaints about questionable medicinals and do-it-yourself therapeutic devices. In one month 24 seizures were made, of which 17 were alleged to be false and misleading claims.

* * *

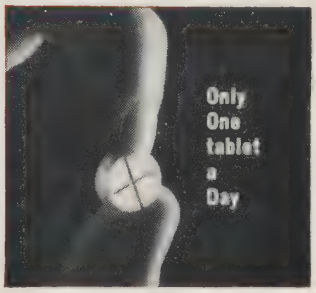
Veterans Administration in May cancelled all plans for reductions in employes and hospital beds after deficiency appropriation of $2.4 million was signed by the President. VA said fiscal shortage resulted in drop in agency's collections from insurance companies for hospitalization of insured veterans.

* * *

National Academy of Sciences and National Research Council have joined American Heart Association in warning against any "major changes" in U. S. diet until more is learned about role of cholesterol in heart disease since "the question of how much and what kind of fat we should eat remains unanswered."

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Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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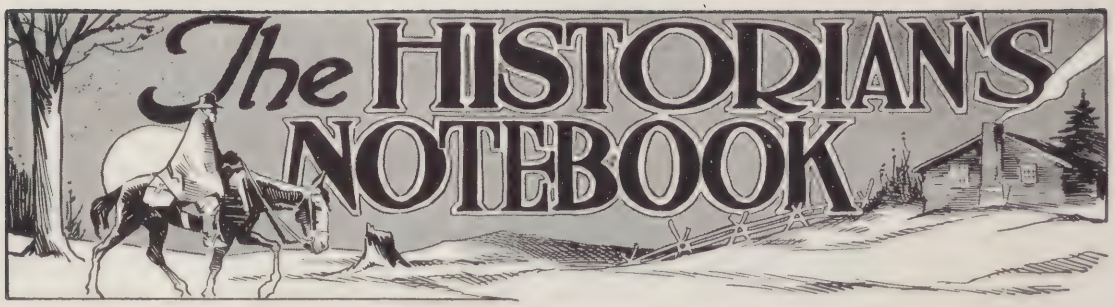
Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Biological Economics

MARTIN FISCHER, M. D.

PART II

(Concluded from June Issue)

NOW what has all this to do with you? A great deal, I venture to suggest, both in the material world and in that of the spiritual.

Under first head I have tried to convince you that nothing physiologically superior, is attained without work. Hence this easy dispositon of all those who, like Reuther, wish to get more and more for less and less; and of the ideals of the communists, the socialists and the do-gooders who would make distribution to everybody's needs from an empty sack.

Don't Sneer

Luncheon clubs have long been sneered at. You are primarily "business" men, they tell you, with the term carrying an uncomplimentary connotation. You are not "professional," so they say, on which account we must define our terms. The professional is the man who gives more than he receives and makes no usurious charge for the material or the service he supplies. It is on this account that the doctor ranks highest even in the learned professions—the priest lacks knowledge of the material world; and the lawyer has too much of it.

Of Business and Men

Wherewith we come to the business man who, too, has within himself all the potentialities of the professional.

I cite Richard Cobden, my favorite of the economists (1804 - 1865) in illustration. At thirty, he was a successful merchant, a printer of goods and a rich man. Wearied in his success, he entered Parliament to stand against the corn laws and for the principles of free trade. Listen to this prediction of his, made circa 1850: "Peace will come to this earth when her peoples will have as much as possible to do with each other; their governments, the least possible."

Laughter Is in Order

My students used to amuse themselves by their examinations into my politics. I was not a Republican (spelled with a capital), I told them, because the Republicans are the lowest form of all political life—except of course the Democrats (again spelled with a capital) who are lower still. If you really want to know what is my politics, be informed that I am a Cleveland Democrat, an anti-imperialist, a free trader and a carrier of the gold standard. More tersely put, I am the dodo.

Fundamentalist

But let us get back to Cobden, 1843, and his estimate of the business man:

"In the close council of every king, or president, or prince, should be a man of affairs whose life is devoted to commerce and labor, and the needs and requirements of peace. His work is of far greater moment than that of men-of-war.

"Battleships ever form a suggestion for their use, and as long as we have armies, men will kill, fight and destroy. Soldiers who do not

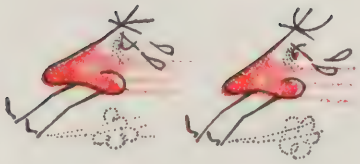
Read before the Kiwanis Club, Covington, Kentucky, July 17, 1957.

The Author

● **Dr. Fischer, Cincinnati, is emeritus professor of physiology, University of Cincinnati College of Medicine.**



running noses . . .



and other hay fever symptoms

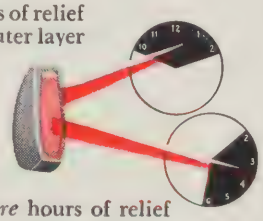
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action—systemically—with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
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TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

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want to fight are not of this earth. Prepare for war and war will come. When government gives to the arts of peace the same thought and attention that it gives to the arts of war, we will have peace on earth and good-will among men. But so long as the soldier takes precedence of the business man in the political courts of the world, famine, death, disease and want will crouch at our doors.

"Commerce is production, war is destruction. The laws of production and distribution must and will be made a science; and then and not until then will happiness come to mankind and this earth serve as a pattern for the paradise of another life, instead of being a pandemonium."

From the Material to the Spiritual

What I have tried to say has been better phrased many times. I quote from Elbert Hubbard: "Once, a businessman was a person who not only thrived by taking advantage of the necessities of people, but who also banked on their ignorance of values. But all wise men now know that the way to help yourself is to help humanity. We benefit ourselves only as we benefit others. And the recognition of these truths is what has today placed the business man at the head—he ministers to the necessities of humanity. . . . There are no menial tasks. The physical reacts on the spiritual and the spiritual on the physical, and, rightly understood, are one and the same thing. We live in a world of spirit and our bodies are the physical manifestation of a spiritual thing, which for lack of a better word we call 'God.'

"We change men by changing their environment. Commerce changes the environment and gives us a better society. To supply water, better sanitary appliances, better heating apparatus, better food, served in a more dainty way—these are tasks worthy of the highest intelligence. We have ceased to separate the secular from the sacred. That is sacred which serves."

The Challenge

I close by asking you to substitute in your mind's eye for the *threat* of leisure, the *challenge* of leisure. Where might it lie?

The problem of sickness as a cause for the sorrows of mankind is being well licked. In 1900 the life expectancy of us in the United States stood at scarce 50 years. Today it is over 70. And we are not going to be held here, for the biologically calculated life expectancy of man is 140 years. With what and how do you propose to fill in this added time?

The Malthusian law since its birth in the early years of the last century continues—so many live as can live miserably or are content to live miserably. More and better food are demanded to feed the ever increasing world population. Need for the solution of this problem seems so far removed that we will not consider it.

So let us take one closer to hand and more definitely in the category of what the businessman can do to aid. We do not hear much from the customs unions of today, even though I consider their debatings the most fundamental for the solution of our political problems. Open trade made Britain the empire! The obliteration of a customs barrier allowed Austria and Germany to unite. It was a union of free trading states and provinces that melted into Germany; and always remember the history of the Hanseatic League.

Farewell

Don't forget that all these items were the thoughts and works of business men!

As Phillips Brooks put it, "Do not pray for easy lives; pray to be stronger men!"

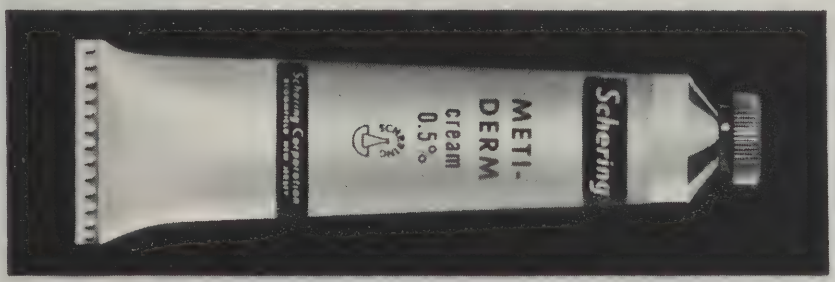
The Historical Background of Chemistry, by Henry M. Leicester, Ph.D. ($6.00. *John Wiley and Sons, Inc., New York 16, N. Y.)* The author, an outstanding student of the history of chemistry, is well known to many Ohioans for his teaching days at Oberlin College and work for the Midgeley Foundation at Ohio State University. This book has a greater appeal to the reader because it develops the story of chemistry through the thoughts and ideas of chemists rather than through the details of their lives. Basic ideas arise in various places. Gradually these are united, modified, supplemented and at last announced in what appears to be a new concept. This concept in turn influences and alters subsequent theories and so the potentially endless progress of science results.

The Person Behind the Disease, by Julius Bauer, ($3.50, *Grune and Stratton, New York 16, New York.)* This book's objective is to elaborate on the fundamental principles of the holistic concept of medicine. The author feels that this concept has been threatened by the tendency to split off more and more branches from the tree of the science and the art of preventing, curing or alleviating human ailments, that is by the ever-increasing specialization in medicine. This concept dates back to the days of Plato who first realized the simultaneous involvement of mind and body during physical illness. This was actually the birth of what we call today psychosomatic medicine. There was a long way to go, however, from the intuitive concept of psychosomatic unity to the hallucination of its nature, its mechanisms and its scientific application to the practice of medicine.

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(1) Noojin, R. O.: South. M. J. *49*:149, *162*:1379, 1956. (3) Goldman, L.; Flatt, *25*:75, 1955. (4) Frank, L., and Stritzler, (5) Robinson, R. C. V., and Robinson, (6) Canizares, O.; Shatin, H., and Rosen 1955.

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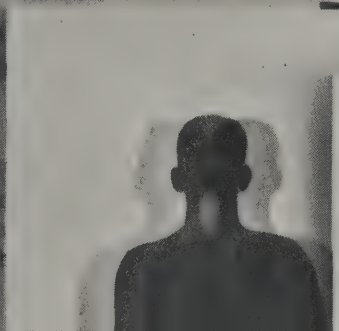
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Vol. 54 July, 1958 No. 7

JONATHAN FORMAN, M. D., *Editor*

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Rudimentary Varicelliform Eruption—Case Reports And Diagnostic Considerations

ROBERT BRANDT, M. D.

VARICELLIFORM eruption is a clinical, not an etiological entity. It consists of a disseminated vesicular to pustular rash, usually accompanied by high fever and other severe systemic reactions, and is superimposed on a preceding dermatosis. The pre-existing dermatosis is mostly atopic dermatitis, predominantly in children; the superimposed disease was first declared to be vaccinia, but it seems that herpes simplex is now more often encountered.

Diagnostic problems often arise, and more so for physicians not familiar with it. This is especially true when the disease is rudimentary or just starting and also when it is very severe. Two cases of the first kind are reported.

Case Reports

Case No. 1. A white boy, was first seen at the age of 9 months with extensive atopic dermatitis. Under topical treatment with Colorado shale he made a quick recovery and, subsequently, had only occasional minor recurrences, which always responded quickly to Colorado shale oil, later in the form of Metashal® Ointment.

On May 14, 1956, at the age of 5 years, the boy was brought to the office because of an eruption in the genital area of three days' duration. Penis and part of the scrotum were swollen and studded with pustules and small circular crusts. There was a small eroded spot on the mucocutaneous junction of the right lower eyelid. Temperature was 99.8 degrees. There were no enlarged lymph nodes and the boy was only mildly ill. It was learned that he had been vaccinated 10 days ago (seven days before the breaking out), and the strong reaction was starting to dry.

Terramycin® Ointment and Elixir of Benadryl® were ordered. After three days, the eruption was practically gone. Atopic dermatitis on the scrotum was barely noticeable.

From the Department of Dermatology and Syphilology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

The Author

● **Dr. Brandt, Cincinnati, is Assistant Attending Dermatologist, Cincinnati General Hospital; Director of Dermatological Service, Longview State Hospital, and Assistant Professor of Dermatology and Syphilology, University of Cincinnati College of Medicine.**

On February 16, 1957 (after an interval of nine months) the boy was again seen in the office with a breaking-out of three days' duration. He presented a typical group of herpes simplex vesicles on his lower lip, and a few individual vesicles on his right shoulder, the dorsum of his left foot and, more numerous, on opposite areas of scrotum and left thigh. Temperature was 99.6 degrees and systemic reactions were mild.

The mother reported that as before the child had had occasional recurrences in patches, with the same quick therapeutic response. With Elixir of Benadryl in addition to talcum powder the herpetic lesions cleared within three days.

Case No. 2. A Negro boy, was first seen at the age of 2½ years. He presented eczematous lesions in ichthyotic skin, not typical of infantile eczema. There were, however, multiple food allergies and a positive family history.

Improvement was satisfactory but slow. Recurrences appeared and the eczema became more typical in appearance and distribution. Metashal Ointment was now applied and there was quick response except for one episode that lasted for almost two weeks. Thereafter, the boy was not seen for 15 months. From later reports by the mother it was learned that during that time he had shown only slight recurrences on his genitalia and that the previously prescribed treatment had always acted promptly.

On April 11, 1957, at the age of 5 years, the child was seen in the office because of a breaking-out of one day's

duration. His prepuce was conspicuously swollen and there was paraphimosis. There were small nodular infiltrates in prepuce and skin of penis and scrotum, and the latter was studded with numerous crusts, obviously dried-up vesicles or, partly, pustules. Temperature was 100.4 degrees.

The picture was confusing, as no history of any possible contact could be elicited and development of a severe pyogenic infection had to be considered. However, a moderately strong vaccination reaction was present, 9 days old, which the mother had failed to mention in her excitement about the ominous looking genital affliction. Chlor-Trimeton® Compound orally and Meti-Derm® plus neomycin were prescribed and the swelling disappeared within 36 hours. After three days, only some roughness of the affected skin was left.

Discussion

The superimposed infection in the first child was vaccinia as well as herpes simplex 9 months apart. In the second child it was vaccinia. In spite of clinical differences between vaccinia and herpes simplex, varicelliform eruptions of both

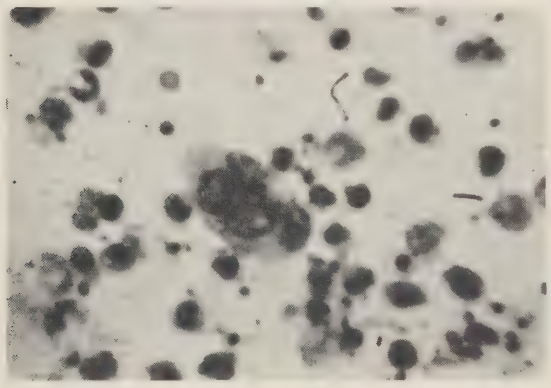


FIG. 1. Tzanck Test. Acantholytic prickle cells reveal the intraepidermal formation of the blister.

causes look very similar and the decision must be based on finding the source in the patient or his surroundings. Vaccinia infection can, of course, not recur after healing, but herpes can. I have seen it develop three times in a patient with extensive atopic dermatitis. Pyogenic superinfection may sometime suggest itself, but this usually develops in recognizable relation to scratching.

The atopic dermatitis that prepares the soil for the eruption need not be pronounced, as we saw in our cases. In this way, the infection may emphasize a minor residue, hardly noticed on fleeting observation. Conversely, the limitation to small areas demonstrates the degree to which healing has been achieved in other places. Rudimentary eruptions also point to an important diagnostic feature as against smallpox.

Smallpox is a systemic disease that involves the skin in its course. Varicelliform eruption is a skin disease that leads to systemic symptoms. Smallpox starts out with a severe systemic reaction, including fever. Shortly before the eruption appears, temperature drops and usually does not rise right along with the rash. Only when pustulation sets in, the temperature again becomes high.

In varicelliform eruption, there is only little systemic reaction, if or as long as the development is limited. The more severe picture, including high fever, unfolds itself with the spreading over large areas of skin. This course of events can be clearly followed, if one has the opportunity of seeing it start from the original herpes simplex on the patient or a member of the family. Once varicelliform eruption is fully developed, the temperature is mostly high (104 to 105 degrees) which, as long as the lesions are still vesicular, distinguishes the disease from smallpox in the comparable phase.

The expression "varicelliform" refers more to the development in crops or rather in stages than to the lesions themselves, which are often umbilicated and subsequently pustular and, therefore, might be termed "varioliform." When only seen at the peak, with both diseases pustular and highly febrile, varicelliform eruption indeed closely resembles variola. Laboratory tests are too slow for a decision on the spot.

Tzanck Test Helpful

There is one speedy test that may offer some help, but only for part of the problem. This is the Tzanck Test, which permits us to distinguish between subepidermal and intra-epidermal blisters, and is routinely done in our Department, for this purpose. The intra-epidermal blister forms through loss of cohesion between prickle cells, and scrapings from the floor of the blister (which consists of epidermis) reveal these elements. In the subepidermal blister the entire epidermis is lifted up; the floor consists of derma and no acantholytic cells are found in scrapings. This test may serve to demarcate pyoderma or erythema multiforme bullosum from varicelliform eruption (or smallpox), but since smallpox as well as herpes and vaccinia develop intra-epidermal blisters, the differential diagnosis within this group cannot rest on the Tzanck Test.

A thorough history, taking into account the points mentioned in the foregoing, especially including exposure to vaccinia or herpes simplex in the patient's surrounding, is of main importance.

Gingivitis and Systemic Disorders

The inter-relation between the health of the oral tissues and general systemic condition is so important that the dentist should not consider the treatment of the oral tissues as an independent subject.—Martin Cibien, D.D.S., Dearborn, Mich.: *Military Med.*, 122:408, June, 1958.

Antibiotic Combination Therapy of Severe Acne Vulgaris

A. P. R. JAMES, M. D.

THE prime consideration in severe pustular acne is the rapid elimination of infection. This will result in minimal psychological damage and prevent unsightly scarring. The older antibiotics are seldom of value. A preliminary study of this problem was undertaken to determine the relative value of two of the newer combinations:

I Alba-Penicillin*—contains 250 mg. Albamycin® Sodium (novobiocin sodium) plus 250,000 units of potassium penicillin G per capsule. (Patients were given one 5 mg. tablet of Delta-Cortef® (prednisolone) daily while taking Alba-Penicillin.)

II Panalba*—contains 250 mg. Panmycin® (tetracycline phosphate) and 125 mg. Albamycin Sodium per capsule.

The most satisfactory of these two combinations was Panalba. Alba-Penicillin while producing good results caused a high incidence of severe side reactions. These reactions could not be prevented by giving steroid therapy.

In this investigation it was interesting to note that 75 per cent of the patients who showed intolerance reacted to more than one antibiotic. In two of the cases the sensitivity as shown by patch tests and ingestion involved every new antibiotic tested. At the Central States Dermatological Meeting last year, in Pittsburgh, cross sensitization between neomycin and streptomycin was reported.**[1] Cross sensitization can be of great clinical significance since reactions to the various "mycins" can be serious. A history of intolerance to any one mycin may be of significance in the administration of another.

The therapist must bear in mind the fact that lesions due to infection are secondary. While treating the infection it is essential that the primary condition receive appropriate therapy.

No two cases of acne vulgaris are identical and of necessity therapy must be idividualized. However, it is possible to follow certain general procedures and apply them as indicated. *Diet* is a major factor. We forbid milk, chocolate, candy, pastry, cream, ice cream, cheese, nuts, carbonated water, and iodinized salt. We limit fat food, fried food, and butter. Proper elimination must be maintained.

*Trade name of The Upjohn Company.

**[1]Edwin Sidi, M. D.; Marc Hincky, M. D.; and Robert Longuevill, M. D.; all of Paris, France, have completed investigation studies and will publish report.

The Author

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Endocrine therapy may be necessary. *Seborrhea* must be controlled. We suggest Fostex,® both for the scalp and to wash the affected parts. It is simple to use and has proved most effective. In all cases presenting pustules or other infected lesions, we attempt to raise the patient's resistance to staphylococci. We have found the most satisfactory results are obtained by giving National Staphylococcus *Toxoid* combined with Bacterial Vaccine. It is very important to give this preparation intradermally. X-ray and ultraviolet therapy are given as indicated. In addition, all patients receive vitamin B_{12} injections and take adequate amounts of water soluble U. S. Vitamin "A."

Case Reports

In this investigation of the action of oral Panalba only severe cases were studied:

Case 1. A 21 year old male was first seen in our office on November 1, 1956. He presented very severe and extensive acne. He had been given many types of therapy including x-ray therapy to the limits of tolerance and had been hospitalized on several occasions by dermatologists.

He was started on our routine as outlined in the foregoing, including vaccine, erythema doses of quartz lamp, and given one capsule of Panalba twice daily. The medication was increased after one week to four capsules daily. After six weeks of therapy all the lesions had healed and the Panalba was discontinued. There has been no relapse and he has continued his other routine therapy. While he presents very extensive scarring he has had an excellent result.

Case 2. This boy was first seen, at the age of 16, in my office on November 19, 1954. He presented very severe acne conglobata of three years' duration. He was given routine therapy with little benefit. On July 9, 1955, Panalba, one capsule two times daily, was given in addition to his other therapy. The dosage was increased on September 24, 1955, to one capsule three times a day. He made slow but steady progress and was dismissed with all the lesions healed and no sign of any activity in the condition on January 15, 1956.

On February 13, 1957, the patient returned with a very severe and extensive recurrence. The face, neck, chest, back and upper arms were practically covered with cysts, ulcerated areas, pus, and scabs. The larger cystic lesions were incised. He was told to wash with pHisoHex® and given neomycin-polymyxin ointment to apply to the raw areas.

He was put on our routine therapy for acne and given

TABLE 1.—*Oral Panalba in Very Severe Cystic Acne*

No. of cases	Males	Females	Average Age	Average Weight	Average Duration of therapy	Side effects		Results	
72	31	41	23	142	36	Urticaria Gastric upset Mild transitory diarrhea	2 1 8	No value Fair Good Excellent	4 9 33 26

TABLE 2.—*Panalba Topical*

No. of cases	Condition	Males	Females	Average Age	Average Duration of therapy	Side effects	Results	
106	Papulo Pustular Acne Vulgaris	56	50	20	8 weeks	2 Venenata	Excellent Fair No value	85 19 2
14	Impetigo	5	9	11	1 week	None	Satisfactory	
6	Pyoderma	3	3	25	2 weeks	None	Satisfactory	
15	Infectious Eczematoid Dermatitis	9	6	31	18 days	None	Satisfactory Fair No value	9 4 2

Panalba, one capsule two times a day. The condition showed only slight improvement and on April 13, 1957, the dosage was increased to four capsules daily. He continued on this regime for four weeks with no visible change. Then he suddenly started to respond. He gained 15 pounds in weight and he stopped developing new lesions. The older lesions rapidly regressed and after two more weeks of intensive therapy he finally presented an excellent response.



FIG. 1. Case No. 2: Patient photographed February 21, 1957.

Approximately 30 per cent of cases showed relapse after therapy was discontinued. These cases were returned to their original regime and in most instances the condition responded satisfactorily within a period not exceeding four weeks. It should also be noted that no case has suffered a second relapse to date.

Three cases of severe acne conglobata in our Panalba series were similar in all respects to a case treated with Alba-Penicillin in our original study. All four patients were boys whose trouble started about the age of 14. The mothers of these boys all gave a history of severe acne vulgaris and their faces were badly scarred. Extensive therapy had little effect prior to the use of Panalba. All four cases suffered severe relapse in about one year. When they responded to therapy the second time they did so suddenly and gained weight rapidly.

Panalba proved so effective it was decided to determine its status when applied topically. An evaluation of its tolerance, effectiveness and its sensitizing properties was taken.

The chart shows two cases of venenata. These two cases were patients from our original series who developed urticarial reactions to oral Panalba. Patch tests with placebo base were negative. These patients were sensitive to the topical antibiotic combination. However, the majority of patients were impressed with the results obtained and felt that the topical medication was of great value.

All investigators are cognizant of the potential sensitizing effect of topical applications of the newer antibiotics. Sixty-two patients who had applied this combination (Panalba) topically for a period of at least six weeks were given small amounts by mouth. Two cases developed mild

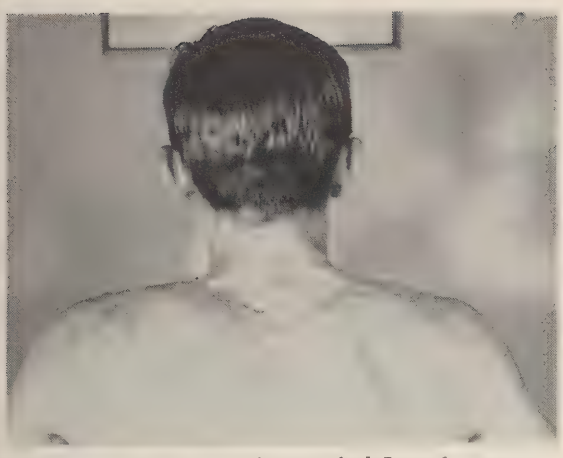


FIG. 2. Case No. 2: Photographed June 6, 1957.

urticaria which responded rapidly to steroid therapy. Unfortunately, we did not test these patients for oral sensitivity prior to the use of the ointment. This limited study would suggest that the incidence of systemic sensitization following topical use is slight.

Conclusions

Panalba in a dosage of *2 to 4 capsules daily* is of great value in the management of severe cystic acne. These patients must be given vaccine therapy and continue their other routine treatment for some time beyond improvement, in order to control relapse.

The topical use of this combination is well tolerated and produces very satisfactory results. It is of particular value in moderate cases of papulopustular acne vulgaris. Further investigative studies will be necessary in order to determine its sensitizing properties.

Pulmonary Hypertension Pain May Simulate Angina

The pain of pulmonary hypertension is worthy of consideration and this pain may mimic angina in almost every respect. While it may be precipitated by exertion or emotion, it may also occur at rest. In addition, the pain accompanying pulmonary hypertension is not dramatically benefited by Nitroglycerin. Often there is a generalized cyanosis.

Since the symptom is associated with increased pressure in the pulmonary circuit, a cause for this increase must be found. Such causes include mitral stenosis, atrial septal defects, patent ductus arteriosus, Eisenmenger's complex, disorders of the pulmonary artery and diffuse pulmonary diseases such as asthma, emphysema and bronchiectasis.—William J. Hand, M. D., Chicago: *Industrial Med. & Surg.*, 27:287, June, 1958.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case presenting, Associated Problems: "Papanicolaou Smear," which was discussed before the Franklin County Pelvic Cancer Delay Committee at its monthly meeting held on May 21st at the Columbus Health Center.

Case No. 61. The patient is a 32 year old white female who eight months prior to hospital admission had routine physical examination. Papanicolaou smear taken. Report received, "Atypical cells; request vaginal and cervical smears." Patient notified but failed to return until six months later because urgency not indicated. Papanicolaou smear again taken. Reported, "Atypical cells, recommend repeat Papanicolaou smear in three to six months."

Patient's physician felt more definitive action required and one and a half months later dilatation and curettage of uterus, and conization of cervix was carried out.

Diagnosis: "Infiltrating squamous cell carcinoma of the cervix, Clinical Stage I.

Impression: Institutional delay eight months. The delay in this case is directly referable to inconclusive interpretation of the Papanicolaou Smear Test report.

Comment: The Papanicolaou smear is a valuable agent for cancer detection. It must remain in our diagnostic procedures. Its misinterpretation constitutes a medical trap. With a report "atypical cells" this patient should have had an immediate biopsy of the cervix. Eight months ago we may have been dealing with a carcinoma in situ which would have required but a simple hysterectomy. Under the present circumstances irradiation and/or radical surgery in this 32 year old woman is indicated. In either event her ovarian tissue will be sacrificed.

Another trap is the "negative" report with the patient assuming that she is all right for a period of several years. A recall visit system must be part of office organization.

The pathologist should not recommend treatment but should clarify the reading of the slide. It is then the duty of the clinician to take the definite steps for other diagnostic procedures. Treatment should not be carried out on the basis of a Papanicolaou test. The pathologist needs a clean cut (cold knife) biopsy for adequate material on which to make a diagnosis.

Chlorpromazine Therapy

Chlorpromazine appears to be now established as a valuable pharmacological agent in the treatment of many medical conditions. Its use is widespread in hospitalized bed patients, as well as ambulatory patients. The drug has several side effects, the most serious of which is bone marrow depression with granulocytopenia.—Gunnar Vetne, M. D.: *J. Michigan M. Soc.*, 57:709, 1958.

Primary Carcinoma of the Lung

Clinicopathological Evaluation of Cases Seen at Autopsy St. Elizabeth Hospital, Youngstown, 1950-1956

ANGELO RIBERI, M. D.

The Author

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FOR the past two decades increasing attention has been paid to the problem of primary carcinoma of the lung. It is of interest that, only fifty years ago, bronchiogenic carcinoma was considered to be almost a rarity and was infrequently incriminated as the cause of death in case history report.[1] However, in recent years, with the publication of numerous significant statistical reports, both in the United States and abroad, the once widely accepted opinion concerning the infrequency of bronchiogenic carcinoma has been dissipated.

Although we realize that the material presented herewith is not extensive enough to permit far-reaching conclusions, it has been of interest nevertheless to review the instances of bronchiogenic carcinoma found in the autopsy material studied at the St. Elizabeth Hospital. We have limited this review to the years 1950-1956, during which period 1,124 postmortem examinations were performed. Only primary carcinomas of the lung were included in this study.

Material

Among the 1,124 autopsies 31 cases of primary carcinoma of the lung were found, one of which was in a female, the other 30 in males. The youngest patient was 32 years of age and the oldest 83, with a mean average of 62 years. This figure compares favorably with those quoted by Crafoord[3], Wiklund[4], and Ochsner and associates.[5-7-8]

Terminal cachexia and emaciation were common findings in all patients, with the ultimate cause of death recorded as pneumonia, bronchopneumonia, pulmonary edema and acute passive congestion of the lungs. In one patient the immediate cause of death was attributed to duodenal hemorrhage and in another to perforation of a large gastric ulcer.

In one case obstruction and erosion of the superior vena cava had occurred. Superior vena cava syndrome due to occlusion of the superior vena cava is a fairly common complication of carcinoma of the right lung. It is easily recognized by the typical puffiness of the face and neck, bulging of the eyes and the development of a marked collateral venous circulation.

In another case a tumor of the right superior pulmonary sulcus was responsible for a typical "Pancoast's syndrome." In the past few years there has been some confusion about the proper designation of these tumors. Some writers have indiscriminately labelled them as "Pancoast's tumors." Since any tumor of the superior pulmonary sulcus, be it primary or metastatic, can give rise to symptoms of neurological involvement, it would seem more appropriate to call these tumors "apical tumors with a Pancoast's syndrome." Unfortunately, when superior vena caval occlusion and/or Pancoast's syndrome are present, the stage of operability has passed.

Twenty-one (64.4 per cent) of the tumors were of the epidermoid or squamous cell variety. Of these, two were of the anaplastic oat-cell type, two were anaplastic and two were multicentric. The remaining 10 tumors included a pleural endothelioma of the left lung, six adenocarcinomas, one mixed squamous and adenocarcinoma, an undifferentiated carcinoma and an anaplastic transitional cell carcinoma. The only female in this group was found to have an adenocarcinoma, which tumor is known to occur more frequently in females.

The smoking habits of these patients were not adequately investigated and therefore no conclusions relative to this problem can be drawn.

Invasion of the adjacent tissues and/or of the regional lymph nodes was the rule. Metastases were found in the mediastinal lymph nodes in 24 patients (77.4 per cent), in the adrenals in 13 cases, in the liver 11, and in the pleura nine. There was controlateral lung involvement in four cases while supraclavicular and aortic metastases were found three times, respectively. The spleen was involved twice, the epicardium, coronary arteries, left ventricle, right auricle, ribs, small bowel, prostate, vertebrae, pancreas, kidney, stomach and brain once. The incidence of one case with cerebral metastases is not very significant

due to the fact that head examination was not carried out in every case.

The left lung was involved in 17 cases as compared to 14 in the right. This gives approximately 57 per cent left lung involvement and 43 per cent right.

In one instance there was recurrence of the neoplasm on the left side two years following pneumonectomy.

Metastases

Bronchiogenic carcinoma, like other carcinomas, metastasizes through the lymphatic and blood channels. However, in considering the paths of dissemination a bronchiogenic route should also be taken into account.

Many of the reports in the medical literature are based on autopsy material and frequently an incidence of metastases of almost 100 per cent is reported. However, occasionally low figures are reported. For example Miller and Jones[6] found metastases in only 30 per cent of a series of 808 cases. Ochsner, Dixon and De Bakey[7] who collected 3,047 autopsy cases from the literature, found the lymph nodes to be involved in 72 per cent of the cases. The liver was involved in 33.7 per cent with the other organ involvement to a lesser degree.

Ochsner and associates[8] in a recent report found mediastinal lymph node involvement in 80 per cent and pleuro-parietal involvement in 40 per cent of their cases.

In many series cerebral metastases have been found in as high as 30 per cent of the cases. This is easily understood when one appreciates the frequent involvement of the pulmonary veins by the growing tumor.

Discussion

Advances in thoracic surgery have made possible removal of carcinoma of the lung which were not considered amenable to surgery prior to 1933 and 1935 when the late Evarts Graham in St. Louis[2] and Clarence Crafoord[3] in Stockholm began to perform lung resections for bronchiogenic carcinoma. Surgical techniques have since improved steadily and more extensive and more difficult procedures are nowadays possible. However, the number of five year survivals is still very low due mainly to a late diagnosis as to the presence of early metastases in many cases when first seen.

In a series of 259 cases reported by Wiklund[4] of the Crafoord's Clinic, 91.1 per cent were men. He found the disease to occur mainly in patients over the age of 50. In his series the right lung was involved slightly more frequently than the left. In addition the lower and upper lobes were involved with equal frequency. The incidence of squamous cell carcinoma was 62.9 per cent. The most common primary symptom was, as in all our own cases, cough, the other usual primary symptoms being: the so-called "influenza," recurrent pneumonias and hemoptysis. One hundred of these 259 cases (38.6 per cent) were resected with 29 deaths in the immediate postoperative period. Thirty-three of the remaining patients survived three years after operation and 25 for more than five years.

In a recent statistical review, Ochsner and associates[8] reported on 1,360 patients with a clinical diagnosis of carcinoma of the lung seen at the Ochsner's Clinic between 1934 and 1956. Of these 442 were subjected to operation with only 33 per cent being found resectable. The tumor was found to affect the right lung in 54 per cent of the cases and the left lung in 46 per cent. Fifty-three per cent of the operated cases had an epidermoid carcinoma, 17 per cent an adenocarcinoma and 30 per cent an undifferentiated carcinoma.

The grave prognosis of the disease is readily appreciated when one considers that only 10 per cent of the Wiklund cases and only 8 per cent of the Ochsner cases survived for more than one year.

Conclusion

It is apparent from this study that early regional lymph node metastases are a very frequent finding in bronchiogenic carcinoma. This fact is a discouraging one, since, as demonstrated by this brief review of the literature, the five year survival rate after surgery is very low.

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Rehabilitation

Rehabilitation is the process of helping people live more effectively. This is a prime goal of modern dynamic psychiatry as well as physical medicine. While more specifically the focus of the former is on psychological factors and the latter on physical factors, neither specialty can be separated from the other as long as human behavior is involved.—Thomas F. Morrow, M. D., and Doris M. Rosenbaum, M. D., Wichita: *J. Kansas M. Soc.*, 59:215, May, 1958.

A New Technique for the Localization of Radiopaque Foreign Bodies

JOHN R. BROWN, M. D.

THE removal of a foreign body from soft tissues may be a very simple matter. However, finding this same foreign body can be a time consuming and traumatic task to both patient and physician. The first attempts at three dimensional localization were made by Shenton[1] who used multiple x-rays and calculated the depth of the foreign body. Willis[3] made more accurate localization possible in two planes by the use of a sterile metal screen in the operative field. Breck and Maylahn[4] in 1950, advocated exploration for the foreign body and placing a sterile clip in the wound. The foreign body was located in relation to this clip with x-rays.

For the past year we have used a technique which is simple and reduces operative time and trauma to a minimum. The hazard of burns from the use of the fluoroscope is completely eliminated. A review of the literature has not revealed the previous use of this technique.

Method

The foreign body is located grossly by anterior-posterior and lateral x-rays (Fig. 1). The area involved is shaved, washed, painted with an antiseptic solution and sterile drapes are applied. Under anesthesia two sterile No. 21 gauge needles of appropriate length are aimed at the foreign body (Fig. 2). One needle is placed perpendicular to the floor, the other parallel to the floor. Using sterile cassette holders, exactly vertical and horizontal films are taken with the portable x-ray machine. The films are viewed and if necessary the needles are placed again in an attempt to come closer to the foreign body (Fig. 3). This procedure is continued as long as necessary.

To date we have not had to replace the needles more than once in order to place the needle points virtually on the foreign body. The needles are left in place and an anatomical dissection carried down to the junction of their points. They can be palpated in the tissues without being moved so that the foreign body can be identified with marked ease and rapidity. As soon as the foreign body is removed the needles are withdrawn and the wound closed in the usual manner. It has not been necessary to drain any of these wounds.

Report of Cases

Case 1. The patient, age 31, was struck in the left thigh by a piece of metal on Oct. 11, 1955. Attempted removal under local anesthesia by his physician was not successful. The patient continued to have some discomfort with an area of numbness above the knee. Examination revealed a nontender movable linear scar 3cm. long. A 13 by 6 cm. area distal to the scar was completely anesthetic.

The foreign body was removed from the left thigh by using the two needle technique on April 12, 1956. The wound healed with no problem. When last seen one month following surgery the area of previous anesthesia had some return of sensation.

Case 2. A 37 year old white male. The patient was

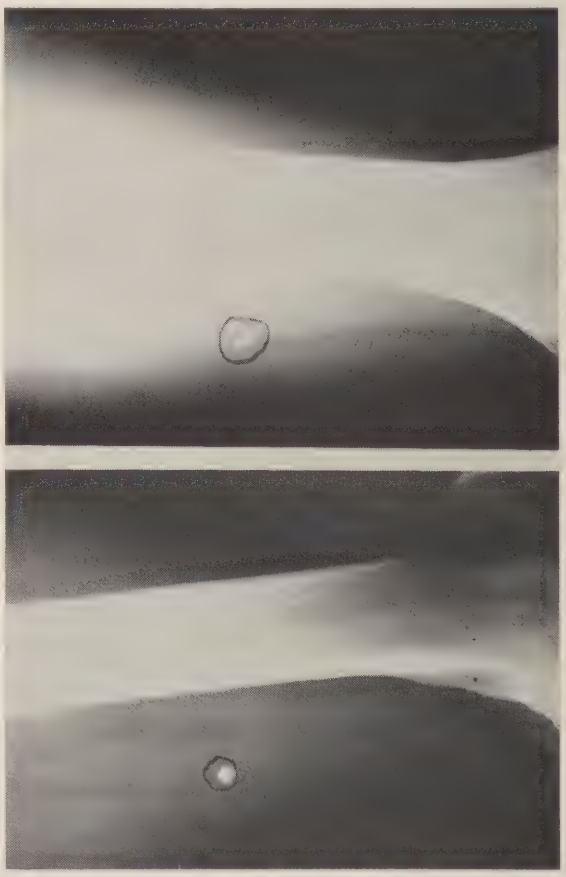


FIG. 1, A AND B. Antero-posterior and lateral films for gross localizaton of the foreign body.

The Author

● **Dr. Brown, Dayton, is Associate Attending surgeon at Good Samaritan, Miami Valley, and St. Elizabeth Hospital.**



FIG. 2, A AND B. Needles have been placed under sterile technique for more accurate localization of the foreign body.

struck in the left medial thigh on Nov. 22, 1956, by a piece of metal off a hammer. The wound healed but he continued to have acute pain distal to the wound on the anterior aspect of the lower thigh and knee with hypesthesia over the medial condyle of the femur. Peripheral pulses were normal.

On Dec. 13, 1956 the foreign body was found embedded in scar tissue in Hunter's Canal. Follow-up studies, one month later, revealed healing per priman with persistent anesthesia over the medial condyle of the femur. The two needle technique was especially helpful in this case. It eliminated the need for a full scale exploration of the saphenous nerve.

Discussion

The technique described above is of value when foreign bodies lie deep in soft tissue. It is particularly indicated when the foreign body lies near large nerves or vessels since it can reduce the risk of damage to these structures to an absolute minimum. If, by accident, the needle should be placed through a nerve of any size it is probable that no appreciable damage will occur. If major vessels are in the area, careful and slow placement of the needles with frequent observation is in order. If the hub of the needle pulsates with the heart beat it indicates the proximity of the point to the

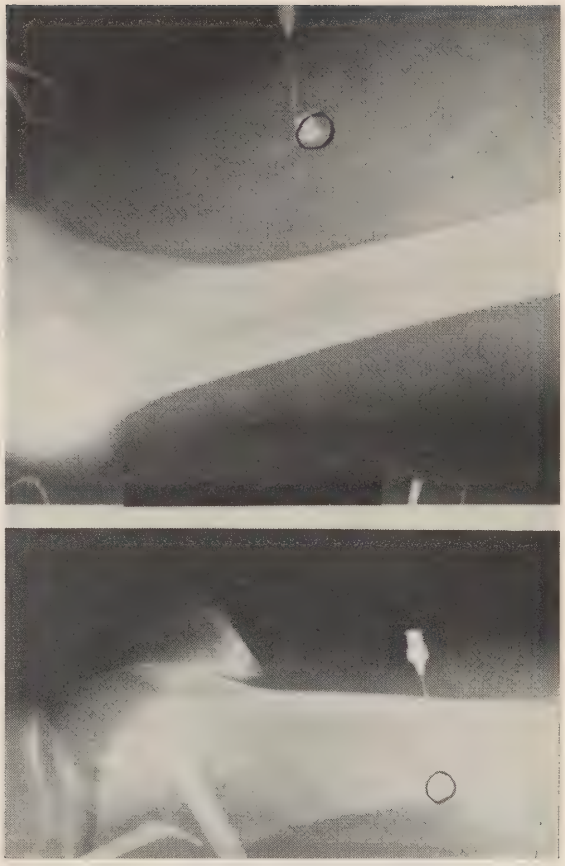


FIG. 3, A AND B. After replacement of the needles the foreign body can be located exactly.

vessels and the needle can be re-directed or stopped at that point.

This technique is not applicable to the large body cavities unless the cavity is opened and solid and hollow organs are protected.

Summary

Radiopaque foreign bodies can be found most efficiently using two needles placed at right angles and serial x-rays taken at right angles. This technique cuts tissue trauma and operating time to a minimum.

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Carcinoma of the Lung

Carcinoma of the lung is a very common disease. It has been more common than carcinoma of the stomach since at least 1940.—Edward F. Parker, M. D., Charleston, S. C.: *J. South Carolina M. A.,* 54:207, June, 1958.

Postural Evaluation of Lower Chest Pain

CHARLES T. WEHBY, M.D.

THE prominence of heart disease and its attendant symptoms has made its presence, or absence, of vital concern to people today. Any indication of abnormality, usually brings the patient to the physician; especially, is this true, if any type of chest pain is encountered. This article deals with chest pain, which is caused by pressure from the abdominal organs, and particularly the splenic flexure of the colon.

This symptom complex is due to gas or spasm in the splenic flexure. This is not relieved by eructation, but the passing of flatus gives temporary relief. However, in some patients this is not possible, and the pain persists. This is the type of patient who consults the physician and his management is the basis of this essay, which deals with postural relief of diaphragmatic pain.

Anatomical Considerations

A review of the anatomy of the splenic flexure clarifies and corroborates its role in the causation of chest pain.. This structure lies cephalad more than any other portion of the colon. It is more fixed than the hepatic flexure and is in close relationship to the spleen, tail of the pancreas and left kidney. It is attached to the diaphragm opposite the tenth and eleventh ribs by a peritoneal fold, named the phrenicocolic ligament. This flexure is so acute that the end of the transverse colon usually lies in contact with the front of the descending colon. Any pathology of the splenic flexure will, due to its relatively fixed position, posteriorly, result in pressure against the adjacent



FIG. 1. Patient shown in position of maximum left diaphragmatic decompression.

organs noted above. Indeed I have noted a tympanitic quality to the percussion note over the left posterior chest below the scapular margin.

With the individual in the erect or prone position the concavity of the diaphragm together with the encirclement of the lower thoracic cage and the tenseness of the abdominal muscles, the path of least resistance for the splenic flexure is against the dome of the diaphragm using the phrenicocolic ligament as a fulcrum. This causes a virtual tamponade of the diaphragm and may involve the phrenic nerve with resulting pain along its distribution. The role of the abdominal musculature is strengthened by the fact that this symptom complex is rarely seen in children or in patients presenting visceroptosis.

It is evident, then, that individuals experiencing left chest pain and pain in the shoulder and arm will feel that the heart may be at fault and will consult their physician. These patients, if the pain is due to spasm or gas in the splenic flexure, will receive prompt relief if they are placed in the position shown in the accompanying picture (Fig. 1).

The patient lies on the right side with the hands placed behind the head. The face is directed laterally, and downward. The left leg is superimposed over the right and flexed at the knee. The left knee should touch the examining table. The right leg lies posteriorly and is also flexed at the knee. This position rotates the thorax, pelvis, and thoracolumbar spine forward and downward to their maximum degree, and allows the abdominal viscera to fall away from the left diaphragmatic area. It is, therefore, obvious that any symptoms due to mechanical pressure in this area, will be completely relieved or appreciably lessened.

By utilizing this technique, the physician should be able to clinically evaluate pain due to diaphragmatic pressure. I have found that it is a simple and valuable technique if properly used. No special equipment or complicated and time-consuming apparatus is required. It is hoped that the postural evaluation of lower chest pain, described in the foregoing, may add to the vast armamentarium already at our disposal for its differential diagnosis.

The Author

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Treponemal Tests;

Kahn, Nonreactive; V.D.R.L., Reactive; Kline, Weakly Reactive; Kolmer Wassermann, Reactive; Mazzini, Nonreactive

OLLIE M. GOODLOE, M.D., M.P.H., and LOUIS J. ROTH, M.D.

BEFORE the advent of the V.D.R.L. test only the Kahn test was given food handlers and patients at the Columbus Health Clinic. At that time we were averaging about 15,000 Kahn tests a year. Our average of positive tests on these food handlers was 6 per cent, or 900 cases. While the blood tests were being taken the food handlers were asked if they had ever had syphilis. Most of them denied having had the disease until a positive blood test came to light, and then admitted having had previous treatment.

Our smug reliance on the Kahn test was rudely disturbed when we started using the V.D.R.L. as a screen test. Much to our surprise, many of the food handlers who had negative Kahn tests showed positive V.D.R.L. tests. Immediate follow-up was done. A large majority of these food handlers with positive V.D.R.L. tests, who heretofore had shown negative Kahn tests, admitted having had previous treatment.

We now take blood tests on about 18,000 food handlers a year. The average still shows 6 per cent to have positive blood tests. Of these 1080 cases, 10 per cent were found to need treatment; 8 per cent of those who needed treatment had neurosyphilis. All these 1080 individuals were interviewed and examined. The great majority of them were diagnosed late latent syphilis. They were questioned about the amount of treatment they had had and when it was administered.

Methods of Treatment

If they were treated before 1944, we assumed that they were treated with Mapharsen® and bismuth. If a spinal test had been taken at that time, and was negative, and they had received a minimum of 10 Mapharsen and 20 bismuth, and showed no subjective or objective signs, no further treatment was advised. If no spinal test had been done at the time of previous treatment, one was now taken, and if this spinal test was negative no further treatment was given.

However, if the patient was irritable, had headaches, general aches and pains but no definite neurological signs, he was given 1,200,000 units of penicillin in oil twice a week for five injections even though the spinal test was negative. It has been very gratifying to find that about 70 per cent of these late latent patients who were treated showed great improvement in their headaches, general aches, irritability and general feeling of tiredness. This feeling of improvement cannot be altogether psychic because the effects of these injections are known to be long lasting.

Read before the Eighth Annual Health Commissioners Institute, Granville, Ohio, July 11, 1957.

The Authors

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False Positive Determination

Many of the food handlers feel well, show no objective or subjective signs of syphilis, yet have a positive V.D.R.L. with a negative or a positive Kahn test. They give no history of having had treatment. In these doubtful cases, a battery test is taken which is sent to the Ohio Department of Health Laboratory. This battery test consists of a Kahn, Kolmer Wassermann, V.D.R.L., Kline, and Mazzini. A majority of these battery tests, however, are also indecisive—part of them being reactive, part weakly reactive and part negative.

These patients are questioned about colds, bronchitis, malaria, pneumonia, any long period of chills or fever, vaccinations, hepatitis and infectious mononucleosis. If there is a recent history of any of the foregoing, the blood test is repeated in three months. If at that time the tests become negative, the previous positive tests are assumed to have been false positives.

Specific Tests

If the battery tests are still indecisive, a Treponema pallidum immobilization (T.P.I.) test is done. In 10 months of 1956, 25 T.P.I. tests were

taken; 20 cc. of blood was sent to the Ohio Department of Health Laboratory. Half of this was sent to the Venereal Disease Research Laboratory at Chamblee, Georgia, and the other half to the Ontario Department of Health Laboratory, Ontario, Canada. While 25 tests is a small sampling, 20 per cent of these showed complete agreement as to false positives; 40 per cent were in complete agreement as to true positives; 12 per cent were unsatisfactory in one or the other laboratory.

Thus we were again faced with the difficult task of determining whether 20 per cent of the 25 T.P.I. cases did or did not have syphilis. These patients were again interviewed; female patients, if parents, were advised to get blood tests on their children as well as their husbands; male patients, if married, were advised to have their wives tested. If these findings were negative and all other symptoms were negative, including the spinal test, we assumed that these cases were false positive.

Some of the questionable cases requested treatment after being informed of the doubtfulness of their syphilis.

Fallibility of All Tests

Our record of 20 per cent disagreement on the T.P.I. tests is due to the fact that the same blood was sent to two different laboratories. It would be informative to have a larger series done in this manner. While the T.P.I. test is more intricate than the spinal test, it is noteworthy that William T. Ford[1] and others gave an excellent demonstration on the degree of correlation that can be expected when identical specimens of spinal fluid are examined in two separate laboratories: 218 of the 264 cases of known neurosyphilis had positive spinal fluid. Of these 218 cases 72, or 33 per cent showed conflicting results.

In our evaluation of doubtful cases, we were influenced first by age. Most of these patients were above 35 years of age. A negative spinal fluid and no other symptoms persuaded us to give the patient the benefit of the doubt. In patients over 65 years of age, no spinal fluid specimen was taken since it is rare to find an active case of neurosyphilis above this age level. The second influencing factor in these questionable cases was Brusgaard's classic report of the fate of syphilitic patients who had received no specific therapy. Of his 473 cases, living or dead, who were examined, 64.8 per cent either died with no clinical or autopsy evidence of syphilis or were living from 3 to 40 years after infection, with no clinical evidence of the disease. This data was the result of a study made between 1889 and 1910 when syphilis was much more virulent than it is today.

One of the most difficult tasks is to try to convey to the patient who has had adequate treatment that while his blood remains positive he still does not have to worry about his syphilis. For this type of patient we have evolved a set of simple answers which the Ohio Department of Health will print and distribute to clinics.

Sensitivity of Specific Tests

Magnuson and Portnoy[2] report that "It is apparent that, in primary and secondary syphilis, the TPCF test is somewhat more reactive than the TPI test. In central nervous system syphilis, including tabes dorsalis, the TPI test was more reactive. In congenital syphilis, a slight advantage went to the TPCF test. In latent and cardiovascular syphilis, the two treponemal tests appeared to be about equally sensitive."

Portnoy[3] and Garson and Portnoy[4], in a series of 303 serums from patients with no clinical evidence of syphilis, but with positive blood tests, report the T.P.I. and the T.P.C.F. results showed 95.9 per cent agreement. In 61 serums submitted as definite biological false positives, the two tests agreed in 98.4 per cent. The T.P.C.F. test has the advantage of being slightly more sensitive, simpler, easier and quicker to carry out than the T.P.I. test.

The T.P.C.F. test gives promise of simplifying the task of arriving at a conclusive diagnosis.

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Thoracic Aortic Aneurysms Pose Serious Threat to Life

It is now well recognized that aneurysms of the aorta, whatever their location, pose a serious threat to life. The development of disabling symptoms and the probability of ultimate rupture are well known. The life expectancy for patients with syphilitic aneurysms of the thoracic aorta has been estimated to be six to nine months. Similar statistics for thoracic aneurysms of other varieties are not available but it is likely that thoracic aneurysms of arteriosclerotic, traumatic or congenital origin also carry a poor prognosis.—F. Henry Ellis, Jr., M. D., Rochester, Minn.: *Minnesota Med.*, 41:335, May, 1958.

Clinical Evaluation of Two Recently Developed Urographic Media

J. N. TAYLOR, M.D., and K. W. GENTERS, M.D.

IT IS the purpose of this paper to report our findings on two recently developed intravenous urographic media. In our clinic Diodrast® was abandoned over 10 years ago because of occasional severe side reactions. Neo-Iopax® was used until Urokon® became available. We felt that Urokon afforded a higher percentage of diagnostic films. Our dissatisfaction with this compound was largely due to the high incidence of nausea and vomiting.

Seeking a more satisfactory radiographic medium, we began to employ both Hypaque® and Miokon.® It then was our clinical impression that these media each afforded consistently as good diagnostic urograms as did Urokon. Furthermore, there seemed to be a definitely smaller number of untoward reactions. This study was then carried out to compare these two media, Hypaque and Miokon, to confirm our clinical impression and also to determine statistically if one drug was superior to the other.

Technical Data

Hypaque is a sodium 3,5-diacetamido-2,4,6-triiodobenzoate which contains 59.87 per cent iodine. It is injected intravenously as a 50 per cent solution. Miokon* is a sodium 5,5-dipropionylamino-2,4,6-triiodobenzoate which contains 57.3 per cent iodine. It too is injected as a 50 per cent solution.

One thousand patients undergoing intravenous pyelography were used in this study. Miokon was administered to 500 of them and Hypaque to the other 500. The patients were unselected and had no preparation prior to the injection of the dye.

TABLE 1.—*Comparative Quality of Excretory Urograms.*

Grade	Miokon		Hypaque	
	Number	Percentage	Number	Percentage
Excellent	230	46.0%	209	41.8%
Good	172	34.4%	179	35.8%
Fair / Poor } Unsatisfactory	98	19.6%	112	22.4%
Total	500	100%	500	100%

From each patient a careful history was obtained concerning allergies such as asthma, hay fever and drug sensitivity.

Selection of the contrast material in each case was picked at random by the nurse and administered by a physician who had no knowledge as to which one was being used. After a scout film was taken, 30 cc. of the contrast material to be used was injected intravenously over a period of two to three minutes. Subsequent films were taken, five, 10, and 15 minutes after the administration of the contrast media. Side reactions were recorded as noted.

The films were graded as excellent, good, fair and poor. The films graded as excellent and good were considered satisfactory to establish a diagnosis, while the films graded as fair and poor did not permit accurate diagnosis.

Results

As shown in Table 1, 500 urograms were obtained with each contrast medium. With Miokon, diagnostic films were obtained in 80.4 per cent with 46.0 per cent of them being excellent and 34.4 per cent good. With Hypaque, diagnostic films were obtained in 77.6 per cent patients with 41.8 per cent of them being excellent and 35.8 per cent good. Unsatisfactory results with Miokon were present in 19.6 per cent as compared to 22.4 per cent with Hypaque.

Reactions

The number and types of reactions are shown in Table 2. Out of 500 patients who were given Miokon, we encountered 48 (9.6 per cent) reactions, while there were 14 (2.8 per cent) out of the same number who received Hypaque. All but two of these reactions were minor and required no treatment. In one case, after injection, hives and difficulty in swallowing occurred. This was thought to be due to pharyngeal edema which was

*We are indebted to the Mallinckrodt Chemical Works, St. Louis, Mo., for supplying us with Miokon for this study.

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relieved immediately after the intravenous administration of 50 mg. of Benadryl® Hydrochloride. Another patient developed hypotension after the dye was given. Although this reaction should be grouped under the more severe ones, the patient recovered before any treatment could be started.

In those patients in this study with a definite history of allergy, the incidence of reactions was higher. Of the 500 patients in the Miokon series, 84 gave a history of allergy and 15 (17.8 per cent) of this group showed side reactions. In the remaining 416 patients who gave no past history of allergy, 33 (7.7 per cent) showed undesirable side reactions. With Hypaque the incidence of

TABLE 2.—*Number and Type of Reactions.*

	Miokon	Hypaque
Nausea and vomiting	10	6
Nausea only	13	0
Itch	2	0
Bitter taste	7	2
Hives	8	3
Sneezing	0	1
Hypotension	1	0
Hives and pharyngeal edema	1	0
Chills	0	2
Flushes	5	0
Dizziness	1	0
Total	48 (9.6%)	14 (2.8%

side reactions in 58 patients with a positive allergy history was 6.9 per cent as compared with 2.2 per cent of the patients who gave no such history. (Table 3.)

TABLE 3.—*Correlation of Reactions with Allergy History.*

	Number of patients with Miokon	Hypaque
History of allergy	84	58
Reactions Patients with allergy	15 (17.8%)	4 (6.9%)
Reactions Patient without allergy	33 (7.7%)	10 (2.2%)

Discussion

Nicolai[1] in a study with Miokon in 750 patients reported only 30 cases, or 4 per cent, with unsatisfactory urograms. Speicher[2] using Hypaque, considered 15.2 per cent of his series as nondiagnostic. In a comparative study of four different contrast media evaluated by Lentino[3] 80 per cent of the urograms obtained with Hypaque were diagnostic and 20 per cent were unsatisfactory. This discrepancy, as regards the percentage of diagnostic films in our series as compared to those just mentioned, is probably due to the fact that the reading of the films is a subjective evaluation. This has been emphasized by Lentino[3] who has pointed out that such studies should always be comparative ones to minimize this factor. Our higher percentage of unsatisfactory results may be due to the fact that our patients received no special preparation prior to intravenous urography.

Compared with other series, our percentage of reactions was rather low. Speicher[2] in his Hypaque study reported 10.4 per cent side effects in 800 patients. These included nausea, vomiting, urticarial reactions. allergic rhinitis, faintness and transitory hypotension. Lentino[3] again with Hypaque noticed the same variety of reactions in his patients; however, the incidence was even greater, being 17 per cent.

The number of side effects in the preliminary report on Miokon by Nicolai[1] coincides with our own figures. Out of their 750 patients, 9.8 per cent experienced one or more reactions. The incidence of reactions is significantly higher in our series in those patients who gave a definite history of allergy. This stresses the importance of obtaining such a history prior to the administration of these compounds.

Lentino[3] has shown that skin and ocular tests with the urographic media to be used are of little value. He believed only reactions following the administration of an intravenous test dose are of significance. We agree and employed this method of testing during the last half of our study. The whole amount of contrast medium to be given is drawn up in a syringe and the injection started with 1 cc. If, after an interval of two to three minutes, the patient does not show any untoward reaction, the remainder of the dye is given within two to three minutes. Should the patient show some kind of side effects, the injection is discontinued. Although we did not encounter any severe reactions during the second half of our study, we feel more safe employing this procedure and hope to minimize the chance of being faced with a serious side reaction.

Summary

Two new intravenous urographic media, Hypaque and Miokon, were tested equally in 1000 patients.

Both Hypaque and Miokon were of equal value in visualizing the urinary tract.

With Miokon, a higher incidence of side reactions was noted.

In patients who gave a history of allergy, the incidence of side effects was higher than in those without such a history.

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Chronic Simple Glaucoma:

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

Three years prior to medical consultation this 49 year old woman suffered a "whiplash" neck injury in an automobile accident. Because of persistent cervical pain, she was treated by a chiropractor. During the subsequent three years she had frequent headaches on the occipital region and noted gradual marked visual loss in the right eye. Optometric consultation confirmed visual disease with an associated upper central visual field defect. The optometrist concluded the automobile injury was responsible, advised continuing cervical manipulations, and prescribed a series of glasses to relieve "eyestrain."

She was finally referred to a neurosurgeon who immediately recognized pallor of *both* optic discs, associated with the typical deep "cupping" of glaucoma. (Glaucomatous cupping begins at the rim of the disc in contrast to the central depression of a physiologic cup which has intervening normal tissue between the cup and the disc edge.) Visual acuity was reduced to 20/100 O. D. and 20/30 OS. Tonometer tension was over 50 mm. of mercury in each eye.

Therapy with pilocarpine drops restored intraocular pressure to normal levels in the low 20's and immediately relieved her headaches. Unfortunately there can be no restoration of her lost visual field and acuity, though further loss will be prevented.

Discussion

Chronic simple glaucoma has aptly been termed "the thief in the night" because without warning it gradually and irreversibly destroys vision. It is usually asymptomatic until far advanced, and therefore discovery of chronic glaucoma is *too late* when made through the patient's complaints. Early diagnosis and preservation of vision is possible only by routine screening examinations. Glaucoma should be suspected under the following circumstances.

(1) If the patient is over 40 years of age—(2 per cent of patients over 40 have glaucoma).

(2) If there is a family history of serious visual loss (glaucoma is hereditary).

(3) If the corneal diameter is 10 mm. or less (average normal is 12 mm.).

(4) If the anterior chamber is shallow and the iris seems to bow forward toward the cornea.

(5) If the frequent, unsatisfactory changing of glasses suggests the possibility of disease.

(6) If there is unexplained aching about the eyes.

The Author

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Coexistence of age over 40 years and any other one of the above listed factors should strongly suggest the desirability of referral to an ophthalmologist. Tonometric measurement of intraocular tension is required for accurate diagnosis. This is done routinely by ophthalmologists in the examination of elderly patients. The intraocular pressure in chronic simple glaucoma is usually not elevated enough to permit detection by finger tension. Finger tension is easily confused with compressibility of orbital tissues, and even when done by an expert may be in error by as much as 10 mm. of mercury.

Tonometry is a simple screening procedure which is readily performed under topical anesthesia (as with Pontocaine® 0.5 per cent). Because of certain contraindications such as the presence of eye infection or diseased corneal epithelium, tonometry should be done only after receiving instruction in technique from an ophthalmologist. Normal tension at one reading does not guarantee absence of glaucoma. Tensions elevated above 27 mm. of mercury require further evaluation by a variety of tests.

It is regrettable that the textbook emphasis on glaucoma suggests it should be detected by findings such as the following:

(1) Reduced visual acuity uncorrectable with glasses.

(2) Visual field losses.

(3) Cupping and atrophy of the disc as recognized by the ophthalmoscope.

Undeniably the diagnosis can be made under these circumstances, but it is TOO LATE! Such a patient will already have sustained severe and

irreversible eye damage. For maximum benefit to the patient, chronic simple glaucoma must be discovered by suspicion of the disease in the over-40 group. Confirmation of the early diagnosis is possible only through tonometry.

With great frequency both ocular and systemic diseases manifest themselves through visual disturbances and eye fatigue. The patient has no way to differentiate these symptoms from those of refractive error. Should he seek aid from a nonmedical refractionist, diagnosis of the true nature of his difficulty and proper treatment are often considerably delayed.

One final comment is pertinent. If glaucoma were a disease which could not be modified by treatment, early diagnosis would be of little avail. The great majority of early cases do respond well to proper use of miotic therapy. By contrast, advanced cases often fail to be controlled by medical or surgical means, and account for 12 per cent of all blindness in the United States.

Relationship of Hyperglycemia To Arteriosclerosis

Our observations suggest that there is a relationship between the frequency of the occurrence of high glucose tolerance curves and the various clinical and laboratory data in our series of cases which may be considered as stigma of arteriosclerosis. The relationship of hyperglycemia to arteriosclerosis is not clear. Whether the hyperglycemia here observed is the manifestation of a true diabetes is questionable. Duncan states that arteriosclerosis per se is not a cause of diabetes. He reasons that if it were, the incidence of diabetes would not be decreasing during the phase of life in which arteriosclerosis is on the increase. However, a hyperglycemic tendency may favor the occurrence or accelerate the degree of artriosclerosis as is the case in true diabetes.

The cause of hyperglycemia in hypertension and arteriosclerosis is not known. O'Hare suggested arteriosclerosis of the arteries of the pancreas as the cause, but Joslin *et al.* found marked arteriosclerosis of the pancreatic arteries in only 23 of 484 autopsies and concluded that arteriosclerosis as a factor in the etiology of diabetes is hardly of great significance.

Goldring and Chasis found that coronary insufficiency occurs more frequently among hypertensives than among nonhypertensives of same age group. Bradley also stated that it is an accepted fact that arteriosclerosis is more common in hypertensives than in normotensives of the same age.—Joseph Weinstein, M. D., and Isidore Stein, M. D., Brooklyn: *New York State J. Med.*, 58: 1857, June 1, 1958.

Selective Readings

The Doctor His Patient and the Illness, by Michael Balint, M. D., with a Foreword by Maurice Levine, M. D. ($7.50, *International University Press, New York 11, N. Y.)* The appearance of an American edition of this text is an event of importance for all workers in medicine. It is a serious consideration of fundamental research on the function, the practice of the personal physician. The book takes as its point of departure some of the basic premises of the current thinking in this field—that the personal physician must deal with problems that are in some ways quite different from those of the hospital physician—that medical work must be concerned with more than diseases and with more than the form and function of individual organs—that much of the medical practice has to do with *patients* as *persons,* their emotions, their response to illness and the like—that psychiatry has now developed enough understanding of human dynamics and interpersonal relations so that it may have something to contribute to the general practice of medicine and, finally, that the time has come for something more solid than admonitions and advice to pay attention to social and psychological factors.

The book presents a discussion of the series of weekly seminars which were the basis of a long-term approach and training project. In these seminars a psychiatrist and a group of general practitioners tried to face the actual facts of medical practice and studied the practitioners' problems, their difficulties and their successes. As our own professor of Psychiatry at Cincinnati says, "this is a searching and stimulating volume on one of the most urgent problems in the practice of medicine on the ways in which the doctor can use himself as one of the major tools in his therapeutic armamentarium."

Economic Institutions and Human Welfare, by John Maurice Clark. ($4.00, *Alfred A. Knopf, Inc., New York 22, N. Y.)* The former president of the American Economic Association and the recipient of many honors in the field has written a vigorous and incisive book on one of the major problems of the modern world. The problem is the relation between economic life in the country and the general welfare of the citizens. This volume explores the myriad ways in which the seemingly narrow technical problems of economics and the vital influence on human achievement and happiness probes deeply into the nature of freedom, into the relation of science to value, analyzes the fallacies of extreme freedom that lead to inhumanity and of extreme control that lead to despotism.



Case No. 41

The patient was a 20 year old Negro, Para I, who died four days and five hours after delivery at term. Her past history was not remarkable. Last menstrual period was September 20. From third month of gestation till term, antepartum history was followed in the dispensary with adequate care. The only abnormalities found during this time were a 1 plus albuminuria in the third month, which cleared spontaneously and a 1 plus ankle edema, which cleared over a two week period in patient's eighth month of pregnancy; both responded well to ammonium chloride and phenobarbital. Her total weight gain was 26½ pounds and the blood pressure was never higher than 124/75. Hemoglobin, 10.9 grams; serologic tests for syphilis, negative; pelvimetry during eighth month revealed a normal fetus, left occipitoposterior (L.O.P.), and adequate room for delivery below.

At term (June 20) the patient was admitted to the hospital in labor with pains every eight minutes and passage of a small number of clots. Blood pressure, 164/90; 1 plus albuminuria, and a 1 plus edema. The membranes were ruptured artificially and meconium stained fluid was observed. When the cervix was 5 cm. dilated, the fetal heart sounds were good and the patient's blood was typed and cross-matched.

The patient was medicated at 1:15 a. m. with 100 mg. of Demerol®, Seconal®, and scopolamine gr. 1/200. The Demerol 100 mg. and Seconal 50 mg. was repeated 45 minutes later. There was rapid progress and the patient was taken to the delivery room three hours and 20 minutes after labor began. A spinal anesthetic (procaine 50 mg.) was given, and a 7 pound, 4 ounce, child was delivered stillborn by Kjielland midforceps (L.O.P.) over an episiotomy at 3:00 a. m. The placenta separated spontaneously and repair of lacerations of the cervix, vagina, and episiotomy were accomplished.

As patient was being transferred from the delivery table, she fell on the floor, landing on her left hip. Blood pressure, 120/70, respirations good, and pupils reacted to light and accommodation. At this time the patient was deeply narcotized. A medical consultant's opinion was that the patient was over-sedated and post-spinal status. A neurosurgical consultant's opinion was moderate shock from blood loss and narcosis.

At 8 a. m., 9:50 a. m., 1 p. m. and 3 p. m. the patient received one unit of blood with much improvement of her general condition in the following 24 hours. The blood pressure rose to 160/90, but with 0.5 grain of phenobarbital the patient became stuporous and developed hematemesis with the rising blood pressure. Blood chemistry revealed a marked liver damage, treated with intravenous glucose, glutaminate and vitamins, but the patient pursued a downhill course and died on the fourth day. Autopsy was permitted.

Cause of Death: The clinical impression was acute yellow atrophy of the liver with uremia, toxic hepatitis, and pre-eclamspia.

Pathological Diagnosis: (1) Acute hepatitis. (2) Lower nephron nephrosis.

TOPIC THIS MONTH:

Maternal Deaths* Involving Liver Disease

Comment

This case provoked great interest and numerous questions by members of the Committee; however, members felt hampered by a lack of laboratory findings, and details relative to the second stage of labor. The Committee felt the toxemia should have been treated vigorously on admission. Further, the Committee questioned the use of Kjielland forceps, and delivery of fetal head as an L.O.P.; was it midforceps? With no mention of specific blood loss, but repair of cervix, vagina and episiotomy, it was assumed *accouchement forcé* was attempted. The four units of blood, it would seem, contributed to her lower nephron nephrosis, although anuria was not mentioned. The Committee voted this a preventable maternal death.

Case No. 43

This patient was a 40 year old, white primigravida, who died undelivered in her seventh month. Her past history revealed cirrhosis at eight years, and later, in 1946, a surgical biopsy of the liver. This confirmed a diagnosis of cirrhosis. Six years later she received transfusions for gastrointestinal bleeding; and her hospital admission (date unknown) was for a similar cause. Her last menstrual period was December 12, but she registered in her fifth month of gestation, May 26; blood pressure 126/70 and weight 145 pounds (normal 136).

On June 20 the patient was seen at home by her (internist) physician because of sudden weight gain. She was admitted to the hospital June 22, pale, weight 165 pounds, blood pressure 120/80, ankle edema, and no fetal heart tones. Laboratory studies revealed 4 plus

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

albuminuria, hematocrit 28 per cent, chlorides 590 mg. per 100 cc., total protein 4 mg., albumin 2.34 mg., globulin 1.6 mg., uric acid 3.8, and urea 35.

Six days later under intensive therapy the patient was improved. There was still a 2 plus albuminuria, and her weight was 168 pounds. The urinary output was good, and a transfusion was given.

On June 27 at 1:50 a. m. the patient vomited blood, her condition became critical suddenly, and a transfusion was started; oxygen was administered. At 2:50 a. m. she developed rectal incontinence with massive hemorrhage and she died at 3:00 a. m. while receiving the second unit of blood. Autopsy was permitted.

Cause of Death: Exsanguination due to rupture, esophageal varices; cirrhosis of liver, Laennec's.

Pathological Diagnosis: Cor pulmonale; portal cirrhosis; arteriolar nephrosclerosis; bilateral pulmonary atelectasis and edema; pregnant uterus, postmorten cesarean section at seven months, stillborn male fetus.

Comment

From facts in this case it appeared the patient should have sought care earlier in view of a history of liver disease. Also, in view of this, she should have been hospitalized for liver function studies in the fifth month. Considering facts available in the case, the Committee voted this a nonpreventable maternal death.

Case No. 44

This patient was a 26 year old, white, primigravida, who died undelivered in her thirty-fifth week of gestation. Her past history was not remarkable. With a last menstrual period October 22, she registered with her physician in her seventeenth week. Physical examination revealed only an asymptomatic mitral systolic murmur. Serologic tests for syphilis negative; blood A-negative. She had five prenatal visits; her course was uneventful until her thirty-third week.

On June 12, (at 33 weeks), the patient was admitted to the hospital with chills and fever of four days' duration, frequency, dysuria, dyspnea of one day's duration, and lower abdominal tenderness; no gastrointestinal symptoms. Physical examination revealed a temperature of 102.2°, pluse 88, respirations 16, and blood pressure 130/80; 2 plus edema of the lower extremities, fundus 3 cm. above umbilicus, fetal heart tones 150 in left lower quadrant. She had generalized uterine tenderness in the right, costovertebral angle tenderness, paronychia of the left index finger. Hospital Course: *Urological consultant:* Toxemia and pyohydronephrosis; *Obstetrics and Gynecology consultant:* Pre-eclampsia and pyelonephritis. She was placed on antibiotics, intravenous fluids and Thorazine® for nausea, 105 mg. in four days, and intravenous vitamins.

June 12. Hemoglobin 13.2 Gm., red blood cell count 4.25 million, white blood cell count 9,200. Urine: albumin 20 mg., white blood cells 0, blood urea nitrogen 39.3, uric acid 12.0 mg.

June 14-19. The patient developed jaundice, melena and fever. The blood urea nitrogen was elevated, CO_2 decreased, cephalin flocculation and bilirubin increased, renal output diminished. Therapy included nasal oxygen.

June 20. Deeply jaundiced, comatose, severely dyspneic. Intake 2,500 cc. Output 185 cc. Temperature 99.6°; pulse 120; respirations 30.

June 21. Almost complete coma; temperature up to 103.°. No fetal heart tones heard. The patient expired at 1:30 a. m. June 22. Autopsy was permitted.

Pathological Diagnosis: Subacute yellow atrophy of liver; enteric hemorrhage, massive; mucosal enteric hemorrhage; pulmonary edema and congestion; aspiration of gastric contents; toxic myocarditis, slight; cardiac hypertrophy, slight; toxic splenitis; toxic nephrosis, slight; intra-uterine pregnancy, 8 months (postmortem stillborn, 38 weeks); icterus, marked.

Comment

This case was voted a nonpreventable maternal death. The Committee was particularly interested in the course of events in this case which apparently began with urological complication, and a mild toxemia. Following the administration of Thorazine (in accepted dosage) signs of liver damage developed, and the patient pursued a downhill course, to death, with renal failure.

Comment of Consultant

The following comment of a consultant, who is a specialist in Internal Medicine, was given at the request of the Committee.

Fortunately, liver disease as a contributing factor to maternal mortality is a rather rare occurrence. The three cases presented are of unusual interest in that two present with acute liver damage and one with the pregnancy complicating a case of chronic liver disease. In our experience significant chronic disease of the liver, such as is seen in portal cirrhosis, is not often associated with pregnancy. There seems to be enough endocrine disturbances present in these individuals to make conception and delivery a rather unusual happening. However, because of the numerous diagnostic procedures and the frequent use of blood or blood products associated with care during pregnancy, it is amazing that we do not see more acute liver disease.

Homologous serum hepatitis may be readily transmitted through contaminated instruments, needles, blood, or blood products. Since all of these are used liberally during the prenatal and postpartum periods, it would seem to me that the incidence of liver disease will gradually increase in this group of patients. Unfortunately, we have no good method of management of this complication, having to rely almost exclusively on supportive therapy. It is mandatory for anyone making use of these instruments or products to be extremely careful that sterilization procedures are adequate to prevent the transmission of this form of liver disease.

One other form of liver disease that is rather rare at the present time is that associated with eclampsia. The incidence of this complication has dropped since the institution of better prenatal care.

One should also bear in mind that acute liver disease may be associated with the use of some of the new tranquilizing and anti-emetic drugs available at the present time.

It is my feeling that the liver disease itself was not curable in the individuals mentioned and that none of these should be listed as preventable maternal mortality.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 56 year old white male was first admitted to University Hospital, Columbus, Ohio, 23 months before his death. His chief complaints at that time were abdominal swelling of six months' duration, a weight loss of 25 to 30 pounds, and exertional dyspnea of gradual onset. He had also suffered from paroxysmal nocturnal dyspnea and orthopnea over a six month period. He had been treated with digitalis and diuretics without much improvement and had had seven abdominal paracenteses. Four months prior to University Hospital admission he apparently had an illness labled S. aureus spinal meningitis and was a patient in another Columbus hospital. He had been on heavy alcohol intake for many years; his family history was noncontributory.

Physical Examination

Physical examination showed a malnourished, chronically ill white male in no apparent acute distress. His blood pressure was 108 over 64. Auscultation of the heart revealed a grade 3 rough low-pitched systolic murmur at the apex associated with an apical systolic thrill. There was also a grade 2 high-pitched blowing pandiastolic murmur radiating from the aortic area, and the first mitral tone was loud and snapping. A prominent third heart sound was heard in diastole. The abdomen was distended and showed flank dullness and a fluid thrill. There was slight pitting edema of both lower legs.

All laboratory tests were normal except for a reversed albumin/globulin ratio, an increased thymol turbidity and an alkaline phosphatase of 11.1 units. The ascitic fluid showed a specific gravity of 1.012 and was sterile. Six blood cultures were negative. Two stool guaiac tests were negative and two were positive. X-ray studies showed only an enlargement of the left atrium. The electrocardiogram showed atrial fibrillation and digitalis effect. The patient was afebrile throughout his 15-day hospital stay. He was maintained on digitalis and showed a poor response to mercurials. He had two abdominal paracenteses. He was discharged to continue on digitalis, vitamins and a low sodium diet.

Presented by

- **Norman O. Rothermich, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Second to Ninth Admissions

In the following 20 months the patient was admitted eight times for complaints of increasing edema and ascites, periods of anorexia, and two bouts of diarrhea. He also had periods of tarry stools and intermittent brief bouts of hemoptysis. On his eighth admission he developed a phlebitis of his right leg and ecchymoses over both limbs. His physical examination showed varying degrees of ascites and pedal edema with accentuation of the edema during his bout of phlebitis. His heart murmurs persisted; his liver size varied and at times was found normal.

Numerous x-ray pictures taken during this period showed a steady increase in his heart size, varicose veins of his esophagus, a scarred duodenal bulb, and a nonfunctioning gallbladder. Laboratory studies during these admissions showed persistently negative blood cultures, intermittently positive tests for occult melena, varying levels in his plasma proteins and rather inconclusive tests for liver function. However, a liver biopsy taken during his fourth admission showed no liver pathologic condition. A hepatic wedge pressure taken at the same time showed normal pressure. The patient was tapped on four occasions. He remained afebrile and was discharged to be followed as an outpatient in the Cardiac Clinic.

Tenth Admission

The final admission came three weeks following his last discharge. In the interim he had accumulated fluid rapidly and had vomited a quart of bright red blood, soon followed by two large bloody stools. Hematemesis and melena recurred after admission. The heart was enlarged to the anterior axillary line, with a systolic apical thrill, a grade 3 systolic murmur at the apex,

and a loud first mitral sound. The second pulmonary sound was louder than the second aortic and no diastolic murmur was heard. Signs of ascites were present.

The white blood count was 13,000 with 84 per cent neutrophils; clotting time was six and one-half minutes, bleeding time three and one-half minutes; prothrombin time was 50 per cent of normal. The blood urea nitrogen rose to 34 mg. but finally returned to 16 mg. Electrolytes and all other laboratory tests were normal. The electrocardiogram showed atrial fibrillation and digitalis-type myocardial changes. Splenoportogram outlined the splenic hilum with the flow of contrast media through the perisplenic veins to the direction of the para-esophageal plexus. The splenic vein was not visualized, thus suggesting obstruction of the splenic vein close to the splenic hilum.

Soon after admission a Sengstaken tube was inserted and the balloon inflated for 36 hours, but bleeding recurred. On three other occasions he bled severely enough to go into shock upon any attempt to remove the indwelling tube. Eight days after admission he presented a picture resembling hepatic coma and was given Glutavene.® He developed massive edema as well as marked ascites, and 12 days after admission he bled again and went into shock but responded quickly to treatment. Bleeding recurred again, however, and he developed chest rales and died on the fourteenth hospital day. During this stay in the hospital he had been intermittently febrile and his temperature before death was 101°F.

Clinical Discussion

DR. N. O. ROTHERMICH: The problem we have before us is that of a 56 year old man who presumably was in good health up to six months prior to his first admission to the hospital and died 30 months later. During this time he developed some malignant type of disease which was progressive in nature, tenacious, never let up, and brought about his death within a period of two and one-half years in spite of all types of therapy. His first symptoms almost certainly make this a case of cardiac disease. I think we can say without any hesitation that this man had heart disease and probably primarily heart disease, and maybe exclusively heart disease, since exertional dyspnea, orthopnea, and especially paroxysmal nocturnal dyspnea are symptoms which are predominantly those of heart disease. The paroxysmal nocturnal dyspnea is a peculiar phenomenon that occurs almost exclusively in left-sided heart disease.

Going through his numerous physical examinations I think you readily recognize that he had all the basic findings and symptoms essential for the diagnosis of heart disease. He had cardiac enlargement, he had arrhythmia and he had significant heart murmurs. Why do I say "significant"? He had not only harsh, rumbling, grade 3 systolic murmurs which are *probably* organic in origin, but he also had diastolic murmurs which are *certainly* organic in origin.

A diastolic murmur, you remember, is caused by a flow of blood into the ventricle. If it is blood returning to the ventricle through an insufficient semilunar valve, it will be a pandiastolic murmur usually beginning in the base and perhaps radiating out to the apex. If it is due to blood moving from the left atrium into the left ventricle but held up by resistance, then the murmur is usually diastolic near the apex and most often late diastolic or presystolic in timing. His physical examination describes several different types of diastolic murmurs. At first the murmur was heard throughout entire diastole, but later on the murmur was heard at different times during the diastole.

General Anasarca

The fifth finding that would suggest heart disease is the general anasarca. He had massive edema of his extremities and even more massive fluid accumulation in his abdomen—an ascites that was almost intractable. You will notice that within the six months prior to his first hospitalization he had seven abdominal paracenteses.

When we read in the history that he had had a heavy alcohol intake over many years we might wonder as to the status of his liver, and with this massive ascites there is a strong temptation to feel that he had liver disease. As you read some of the laboratory data on the first hospitalization you might be more inclined to think that he had primary liver disease, particularly with the very low albumin and the reversed albumin/globulin ratio. But this man had seven abdominal paracenteses in a short period of time before he came in and that alone can deplete the albumin stores of the body. I think this contention is borne out by the fact that later his albumin rose to fairly respectable and normal levels.

His liver function studies on the first admission were just slightly on the borderline of abnormal, and the subsequent studies of his liver all were remarkably normal. It is significant too that during the fourth hospitalization he had a biopsy of his liver, which was said to be entirely normal. Furthermore, even though he had massive liver enlargement on his first admission, on subse-

quent admissions there were times when his liver was relatively normal in size or had receded to where it was no longer palpable. It is true that a man who develops cirrhosis may have a huge liver at the outset, which will gradually shrink to very small size, but this man's liver would get large, shrink and then get large again, apparently varying with the degree of fluid accumulation in his entire body, or with the degree of cardiac failure.

In addition to his heart murmurs, his first mitral sound was loud and snapping—a finding that we like to link with mitral stenosis. When we tried to analyze the valvular disease of this patient we were tempted from the nature of the murmur to think that he had an aortic regurgitation, but then I looked back at the blood pressure and found 108 over 64. It is very,very unusual to see an aortic insufficiency without an elevation of the systolic blood pressure and of course a very low diastolic pressure. And in all subsequent admissions the blood pressure was also comparatively normal. But a second factor that would lead you away from a diagnosis of aortic valvular disease is the failure of the electrocardiogram to show a left ventricular preponderance as evidence of left ventricular hypertrophy, which was also confirmed by the x-ray studies. Without these three symptoms present I would be very much disinclined to a diagnosis of aortic insufficiency.

Mitral Valvular Disease

Because of his left-sided heart disease, because of the type of heart murmurs, and excluding aortic valvular disease, we must assume that the man had severe mitral valvular disease. We can assume that he had rheumatic involvement of the mitral valve, but we must at the same time assume that this was relatively insignificant in a clinical sense since he got along for so many years without any complaints. Something else must have happened to bring on this extreme, intractable failure.

In the history of the first admission it states that the man lost 25 to 30 pounds in that first six month period and this happened during a period when he accumulated fluid. Instead, he should have *gained* a lot of weight. He had a lot of weakness and on admission he was extremely malnourished. Then there is briefly mentioned the story of his S. aureus spinal meningitis four months before he came into University Hospital. Now staphylococcus meningitis is a disease of major significance, and I think we must assume that he had some acute febrile infectious disease in which *Staphylococcus aureus* must have been demonstrated in the spinal fluid. If this is true, then we can be certain that he also had staphylococcus septicemia, and I think it is only fair to assume that his staphylococcus septicemia was the disease that brought about his great debility, his loss of weight, malnutrition and weakness.

But what can a staphylococcic infection in the spinal canal or even in the blood stream do to the heart to set off this mechanism of extreme failure? It is well known clinically that the production of insufficiency of a valve very rapidly will lead to the most intractable type of failure. In the early days of mitral commissurotomy, surgeons learned that the production of a significant degree of mitral insufficiency was a surgical complication that proved catastrophic. The patient would go into massive cardiac failure and die within 24 to 48 hours. Also you are taught, and we know from experience, that a ruptured aortic cusp followed by acute valvular insufficiency will lead to very rapidly progressing cardiac failure and death within a short period of time.

Bacteremia?

We might assume that this man had staphylococcus blood stream infection, that the organism infected a previously damaged mitral valve, and that in the course of this disease labeled as meningitis he had some accute staphylococcus endocarditis which caused ulceration of his valve and thus accentuated rather rapidly his insufficiency. We used to see such a lesion very seldom prior to the days of antibiotics. Acute endocarditis was not a rare disease by any means, but the patients died so fast from their sepsis that their cardiac disability was overshadowed by their severe sepsis. They would die as a rule within six weeks and thus we did not come across this strange entity that I think we are dealing with today—of ulceration from acute endocarditis in which the basic bacterial disease was cured by our present antibiotic therapy, leaving the man with a severe insufficiency which throws him finally into intractable and lethal cardiac failure.

Let us briefly discuss the other types of left-sided heart disease that a 55 year old man can develop. Naturally the first thing you think about is coronary heart disease, but there is nothing in this history that would suggest that this man actually had a coronary thrombosis or myocardial infarction. Could he have active rheumatic heart disease? Yes, it is entirely possible for a person to develop rheumatic fever earlier in life, have little or no symptoms and get along quite well until late in adult life. However, it would be very unusual and highly unlikely for a man to have rheumatic valvular heart disease for a long

time and then go into seemingly intractable failure which is unresponsive to good management and to go steadily downhill and die within a matter of two and one-half years.

Could he have had hypertensive heart disease, which is so common at this age? Centainly there is nothing in his history to suggest that. Could he have had one of the more exotic types of heart disease? He could have had Pick's disease, or adhesive pericarditis, but that would not explain anything about what was going on inside his heart. He may have had some sort of band formation across his inferior vena cava at its entrance to the heart. This would easily explain all of his accumulation of fluids but again would have nothing to do with his heart or with his lungs, and I think then we can discard both possibilities.

Another unusual disease that affects the heart is primary amyloidosis. It occurs in individuals of this age level and always involves the myocardium like all other skeletal muscles. But primary amyloidosis almost always has conduction disturbances such as intraventricular and atrioventricular heart block and usually leads to complete heart block. We might also mention hemochromatosis and a lot of other diseases, but I just don't believe there is a remote possibility of them in this case.

Ascites

There are other symptoms in his clinical course that make one wonder if some other factors did not complicate the picture. In the first place the outstanding feature of fluid accumulation all through his illness is that it was in the form of ascites. Athough there were times when he had massive dependent edema, still the thing that pervades the whole story is the accumulation of ascites.

Then we note that a hepatic vein wedge pressure was taken and that this pressure was normal. A wedge pressure of the hepatic circulation gives some index of the pressure in the portal circulation, and if that is normal it is hard to explain his ascites, it is hard to explain his heart failure, it is hard to explain everything unless he had a portal vein thrombosis, in which case then there would be a normal wedge pressure in a hepatic vein.

Portal vein thrombosis is a complication of considerable magnitude. I have only seen a few cases in the past 20 years. Those I have seen developed massive ascites and edema below the diaphragm and did not survive more than a few months. However, I suppose that with energetic management, diuresis, etc., and with greater adequacy of collateral circulation, one could have a portal thrombosis and survive for a reasonably long period of time. He did have bleeding varicosities of the esophagus and did show at one stage a thrombophlebitis in one leg, which would support the concept of an increased clotting mechanism. Finally the fact that he was in congestive failure would make him a likely candidate for vein thrombosis anyway.

So, Dr. von Haam, I have to offer you a man who went into severe, intractable cardiac failure at the age of 56, who had evident heart disease with quite obvious organic valvular disease, who responded poorly to cardiac management although on a couple of occasions his heart failure did presumably subside entirely. Eventually he went downhill and died with this problem of massive anasarca. I think that he probably had rheumatic heart disease with involvement of the mitral valve, that he may have had an acute endocarditis which caused valvular ulcerations and accentuated his insufficiency, and that he may well have developed a portal thrombosis to complicate the picture. This could well explain his massive ascites and the esophageal varices.

General Clinical Discussion

Dr. William Molnar (radiologist): On the first admission this patient had only left atrial enlargement. Later there occurred some right and left ventricular enlargement, so we could easily state from a radiological point of view that he had regurgitation but no mitral stenosis or aortic regurgitation. The films taken at splenoportography did not demonstrate the splenic vein or the portal vein. But we have evidence that there were increased venous channels around the spleen which had direct communication and anastomotic channels to the para-esophageal plexus and to the azygos system.

I wonder if the patient had a splenic infarct or a portal vein thrombosis or some chronic inflammatory process in the form of pancreatitis which may have caused this obstruction or pressure on the splenic vein. I do not believe that his ascites was due to cardiac failure, but I believe that there was some other underlying disease which caused the ascites.

Clinical Diagnosis

1. Rheumatic heart disease, probably inactive.
2. Acute bacterial endocarditis with severe insufficiency of the mitral valve.
3. Portal vein thrombosis.
4. Bleeding esophageal varices.

Pathological Diagnosis

1. Acute bacterial endocarditis with perforation of mitral valve.
2. Septic myocarditis.
3. Fibrosis of pancreas with obstruction of splenic vein.
4. Phlebosclerosis and calcification of splenic vein.
5. Esophageal varices with hemorrhage.
6. Septicemia.

Pathological Discussion

Dr. Emmerich von Haam: I may state that the official clinical diagnosis at the time of the patient's death was liver cirrhosis with bleeding esophageal varices. The patient was poorly nourished and his abdomen contained 3000 cc. of ascitic fluid, but he had no pedal edema when he died. The pericardial sac was partially obliterated by diffuse fine adhesions. His heart was enlarged and weighed 475 grams. The mitral leaflets were slightly thickened and nodular and the right leaflet contained a sharply punched-out hole at its base measuring 15 by 8 mm. The base of the left valve leaflet showed a saclike dilatation measuring 12 by 9 mm. which was filled with friable vegetations. Otherwise the valves of the heart appeared normal.

The lungs were heavy and edematous and the trachea was filled with aspirated blood which probably came from his terminal hemorrhage and was the immediate cause of death. The spleen was enlarged and weighed 500 grams. The splenic vessels were encased in dense fibrous tissue surrounding the pancreas. The liver was slightly decreased in size, soft and congested. The gallbladder was filled with small black stones. The pancreas was small and fibrosed with dilated ducts and complete disappearance of the normal acinolobular pattern. The esophagus showed a 13 cm. linear erosion and the stomach contained 20 cc. of coffee-ground material.

The remaining portion of the gastrointestinal tract was not remarkable. The kidneys were large and contained numerous small yellow and red infarcts. Examination of the remaining parts of the body including the brain was grossly not remarkable.

Microscopic Examination

Sections through the heart valve showed endocardial thickening with abundant vegetations containing numerous bacterial colonies. No vegetations were present on the margin of the perforation. The myocardium was riddled with abscesses containing colonies of cocci. Similar bacterial abscesses were also found in the spleen, liver, kidneys, brain and spinal cord. The esophagus contained varicose veins with ulceration of the mucous membrane.

The liver showed congestion with very mild nutritional cirrhosis. The pancreas showed changes of chronic pancreatitis with severe interstitial and peripancreatic fibrosis. The wall of the splenic vein was thickened with extensive calcification and marked compression of the lumen. The spleen showed the typical changes of congestive splenomegaly with adenofibrosis.

In summary then I may state that this patient suffered from bacterial endocarditis which had produced a perforation of the mitral valve causing acute mitral insufficiency. Modified in its lethal course by the use of antibiotics, it nevertheless continued and finally led to septicemia with bacterial embolization. The ascites and the esophageal varices were due to a severe nonthrombosing pylephlebitis of the splenic vein due to severe chronic pancreatitis. I wish to congratulate Dr. Rothermich for his fine clinical analysis by which he recognized the fatal heart disease of this patient, and Dr. Molnar for his interpretation of the splenoportogram which suggested the true cause of his portal hypertension.

Treatment of Myocardial Infarction With Anticoagulants

The study embraces a six-year period (1951 through 1956) and deals with the results obtained in 136 patients with acute myocardial infarction who were treated with anticoagulants. Not included in the study are those patients who died within 24 hours of admission. . . .

The patients were arbitrarily (and retrospectively) divided into "poor risk" and "good risk" groups, roughly according to Russek's criteria, depending upon the findings on the first day of illness. If any of the following were present, the risk was considered poor: (1) intractable pain (2) persistent shock (3) heart failure (4) cardiomegaly (5) serious arrhythmia or block (6) presence of diabetic acidosis or other serious concomitant illness and (7) history of previous myocardial infarction. All other patients were considered good risks, regardless of age. According to these criteria, 76 of the 136 patients were classified as "poor risk" and 60 were "good." All were given full anticoagulant therapy.

Of the 76 poor risks, 20 (27 per cent) died of their illness. Of the 60 patients considered good risks, one case proved fatal (1.7 per cent). The overall mortality rate was 15.4 per cent.—John F. Stegeman, M.D., et al., Athens, Ga.: *J.M.A. Georgia,* 47:72, February, 1958.

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]...6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

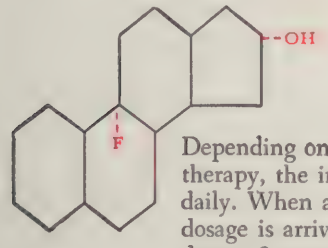
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...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

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Group Life Insurance Plan for Members of the

Coverages of $10,000, With Option To Buy $10,000 More, Will Be Underwritten by The Union Central Life Insurance Co., Cincinnati

AN excellent Group Life Insurance Plan, available to all members of the Ohio State Medical Association who have not attained the age of 75 years, was adopted by The Council on June 8.

All members should watch for the direct mail information on the plan which will be sent in the near future, accompanied by an application form.

The coverage is being underwritten by The Union Central Life Insurance Company of Cincinnati.

The insurance contracts will be sold and the plan administered by Floyd L. Turner, C. L. U., and Arthur E. Shepard, C. L. U., general insurance agents of Columbus, doing business as Turner & Shepard, Inc.

Possible To Get $20,000 Coverage

The amount of insurance offered any one member is $10,000 **without** evidence of insurability and an option to him to buy at the same rate an additional $10,000 **with** evidence of insurability.

At age 65, each $10,000 purchased will reduce to $6,750 for ages 65 through 69; to $4,500 for ages 70 through 74.

The premium payable is on a step-rate basis according to age brackets with the exception of the 65 to 75 age bracket when the premium remains constant but the insurance reduces as stated in the foregoing paragraph.

Available To Employees of Physicians

To comply with the State law, life insurance coverage of $2,000 under the plan is available without evidence of insurability **to any employee of OSMA members who may desire to participate.** The premium on coverage for employees is on a step-rate basis according to age brackets. The coverage for employees includes all features of the coverage offered to their physician-employers.

Double Indemnity; Waiver of Premium

The group insurance coverage includes double indemnity for accidental death and dismemberment.

Waiver of premium in event of permanent and total disability prior to age 60 is included.

There are no exclusions for death while in the military service or as a result of aviation. However, double indemnity, **does not** apply for accidental death or dismemberment in case of death or injury resulting from military service or aviation **except commercial airlines.** Also, the waiver of premium provision **does not** apply in disablement resulting from military service or aviation, **except commercial airlines.**

Paid up Permanent Insurance Through Dividends

The group insurance contract includes full settlement options, i. e., like those in individual insurance contracts.

Dividends will be used to purchase paid-up permanent insurance for each member participating in the plan.

The paid-up insurance purchased from the dividends may be cashed in by the participating member.

All OSMA members, whether or not engaged in active practice, are eligible to participate in the plan.

A participating member will be permitted to convert his group insurance **without evidence of insurability** to a permanent form of life insurance after five years participation in the plan; or at termination

OSMA Voted by Council at June 8 Meeting

Employees of Members Also May Purchase Policy; Many Excellent Features Included, Such as Waiver of Premium and Double Indemnity

of membership; or at age 75; or when the amount of insurance reduces. Premium charged on converted insurance will be the premium charged at the age at time of conversion.

Need 1,000 Enrollees To Make Plan Effective

The plan will become effective as soon as the first 1,000 participating members or employees have been enrolled.

After the initial state-wide enrollment period (i. e., perhaps 60 days), members and their employees may enroll at semi-annual renewal dates. **However, those not enrolling during the initial state-wide enrollment period will have to show evidence of insurability in order to secure coverage at a later date.**

New members of the OSMA and their employees may enroll without evidence of insurability on the semi-annual renewal date following admission to membership in the Association.

Tabulation on Premiums Charged

The following tabulation shows the premiums charged for the Ohio State Medical Association Group Life Plan, including an administration fee, and compares these with the higher premiums charged for **individual** term insurance contracts as issued by the same company—the Union Central.

OSMA Group Life Insurance Plan (Semi-Annual Premium)			Individual Term Insurance [1] (Semi-Annual Premium)	
Under Age 30		$ 23.40	Age 29[2]	$ 50.80
Ages 30 through 39		$ 31.15	Age 30[2]	$ 52.40
Ages 40 through 49		$ 53.65	Age 40[2]	$ 77.20
Ages 50 through 54		$ 86.95	Age 50[2]	$121.80
Ages 55 through 59		$125.30	Age 55[2]	$177.30
Ages 60 through 64		$183.45	Age 60[2]	$206.90[3]
Ages 65 through 69	($6,750 Ins)	$183.45	Not Available	
Ages 70 through 74	($4,500 Ins)	$183.45	Not Available	

[1] Subject to evidence of insurability.

[2] Age shown is youngest age in the group bracket. For other ages in bracket, the individual premiums would be larger.

[3] Accidental death not included.

The semi-annual cost for the $2,000 insurance offered employees under the Ohio State Medical Group Life Plan is about 20% of the amount shown above in the various age brackets in the left-hand column.

Special Committee Worked on Plan

The plan being offered by the Association was formulated after six-months work on the part of a special committee composed of Dr. H. M. Clodfelter, Chairman, Dr. C. C. Sherburne, and Dr. Roger E. Heering. Dr. Clodfelter and Dr. Sherburne are former presidents of the Association.

It was during Dr. Clodfelter's term as president when the House of Delegates of the Association approved a resolution authorizing the Association to present a Group Life Plan to the membership.

(Continued on Page 928)

At that time, this could not be done under the State Insurance laws. This was corrected at the last session of the Legislature when an amendment authorizing the underwriting of professional groups for life insurance was adopted.

The special committee interviewed representatives of agencies applying for the job of administering the plan. It considered suggestions from various insurance companies.

After careful analysis, the committee found that the proposal submitted by The Union Central Life Insurance Company more nearly complied with certain specifications laid down by the committee than any of the other proposals considered by the committee.

Union Central Outstanding Company

The Union Central Life Insurance Company is one of Ohio's leading insurance companies and ranks among the leaders in the insurance field nationally. It was organized in Cincinnati in 1867.

In its official financial statement for the year ending December 31, 1957, Union Central showed the following:

Assets	In excess of $ 800,000,000
Paid to policyholders and beneficiaries to date	In excess of $1,500,000,000
Amount of insurance in force	In excess of $2,400,000,000
Total group insurance in force	$ 715,000,000

President of Union Central is John A. Lloyd, former superintendent of the Ohio Department of Insurance and former member of the Ohio Senate.

Turner - Shepard Agency Experienced

The Turner-Shepard Agency was organized in 1929. It has specialized in association group insurance since 1943. At present it is administering disability group insurance for members of 28 County Medical Societies in Ohio, including the Columbus Academy of Medicine and the Montgomery County Medical Society. In addition, Turner-Shepard Agency administers five regional association plans and five state-wide association group insurance plans, including that of the Ohio Bankers' Association. It has a staff trained in group insurance administration; has four full-time representatives working throughout the state; has working arrangements with insurance brokers in all major Ohio cities. The officials and experienced personnel of the Union Central Group Life Department will assist Turner and Shepard in soliciting members of the OSMA and in handling other details.

Ohio Has 369 Foundations with Assets of $250-Million

Philanthropic foundations in Ohio have assets of $250,000,000 and have made grants of more than $21,000,000 in single years, according to findings of a survey announced by American Foundations Information Service.

The survey revealed 369 foundations in the State, as compared to 162 found in a similar study in 1955. Since the previous survey, total assets have increased by $125,000,000; grants in single years, by $13,000,000.

Among sponsors and supporters of recently discovered foundations in the State are 120 business firms and 249 individuals and families, according to the survey. Predominant fields of interest are education, health and medicine, and various aspects of social welfare.

Ohio Chest Physicians Elect Officers

The following are the newly elected officers of the Ohio Chapter, American College of Chest Physicians: Dr. Harvey Mendelsohn, Cleveland, President; Dr. George Kress, Columbus, vice-president, and Dr. F. G. Kravec, 243 Lincoln Avenue, Youngstown, secretary-treasurer.

Fort Steuben Academy

The Fort Steuben Academy of Medicine and the Committee on Trauma of the American College of Surgeons sponsored the Annual Trauma Symposium in Steubenville recently. Dr. R. Arnold Griswold, professor of surgery, University of Louisville, spoke on the subject, "Prevention of Injury in Automobile Accidents." Discussion was opened by Sgt. R. H. Shaneyfelt, of the Ohio Highway Patrol.

Proceedings of The Council . . .

Preliminary Plans Made for 1959 Annual Meeting in Columbus Next April; A Statement of Policy on Unauthorized Practice Is Approved

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the Columbus office on Saturday and Sunday, June 7 and 8, 1958. In addition to all members of The Council, the following were in attendance: Dr. Charles L. Hudson, Cleveland, chairman of the Committee on Medical Services; Dr. C. C. Sherburne and Dr. R. E. Heering, Columbus, members of the special Committee on Group Life Insurance; Mr. Wayne E. Stichter, Toledo, legal counsel; and Messrs. Nelson, Saville, Page, Edgar and Moore.

By official action, the minutes of the meetings of The Council held on March 1 and April 17 **were approved.**

Membership Data

The following membership data was presented by the Executive Secretary: OSMA membership as of June 6, 1958, 8,896; compared to a total membership of 9,070 members as of December 31, 1957.

Members of the OSMA affiliated with the AMA as of June 6, 1958, 7,828; compared to a total of 8,030 who were 1957 AMA members.

1959 Annual Meeting

After reviewing the 1958 Annual Meeting in Cincinnati which, in the opinion of the members of The Council, was a very successful meeting, The Council discussed plans for the 1959 Annual Meeting in Columbus.

It was decided that the meeting should be held on Tuesday, Wednesday, Thursday and Friday, April 21, 22, 23 and 24. All sessions will be held in the Veterans Memorial Building.

Also, it was decided that the program for the first day would be devoted primarily to cancer and heart disease, and that the Ohio Division of the American Cancer Society and the Ohio State Heart Association should be invited to hold their meetings on that day and present the program material.

Inasmuch as the Ohio State University College of Medicine will celebrate its 150th anniversary in 1959, The Council extended an invitation to the medical school to have its sesquicentennial celebration the week of the 1959 OSMA Annual Meeting. Specifically, The Council voted to invite the Ohio State University College of Medicine to present the Friday program, utilizing, if it desired, distinguished OSU medical alumni. It was understood that the medical school would wish to have a banquet on Friday evening, April 24, and medical alumni class reunions on the campus on Saturday, April 25.

The Committee on Scientific Work was asked to take all of these decisions into consideration and to cooperate with all concerned in working these features into the 1959 Annual Meeting program.

By official action, The Council selected the meeting places and dates for 1961 and 1962 as follows: 1961, Cincinnati, the week of April 16; 1962, Columbus, the week of May 13. Previously The Council had selected Cleveland for the 1960 Annual Meeting the week of May 15.

Constitutions and By-Laws

Action was taken, as follows, by The Council on new constitutions and by-laws of the county medical societies indicated or amendments to the constitutions and by-laws of such societies:

Belmont County—Action was delayed pending a conference between representatives of the medical society and OSMA legal counsel on certain amendments.

Coshocton County—Approved in final form following the adoption of changes suggested by Council at its meeting on March 1.

Jefferson County—Approved as adopted by the society and presented to The Council.

Scioto County—Approved in final form, providing certain typographical errors are corrected and clarifying phrases suggested by The Council are agreed to and inserted.

Van Wert County—Approved in final form following the adoption of changes suggested by Council at its meeting on March 1.

Wayne County—Approved in final form following the adoption of changes suggested by Council at its meeting on March 1.

Unauthorized Practice of Medicine

By unanimous vote, The Council approved a statement of policy regarding the unauthorized practice of medicine by partnerships, associations, institutions, corporations and unlicensed persons, and the ethical status of physicians aiding or abetting, or participating in, such un-

authorized practice. (See page 935 this issue of *The Journal.)* This statement was drafted by the Judicial and Professional Relations Committee and the Committee on Hospital Relations. The committees spent approximately one year studying this question, pursuant to a resolution adopted by the House of Delegates on May 16, 1957. The committees met jointly and held many conferences with specialists, groups and organizations vitally interested in this question, including the Ohio Hospital Association and others. In approving the statement presented by the committees, The Council commended the committees for their excellent work.

By official action, The Council instructed the Executive Secretary to prepare a pamphlet for distribution to all members in which would appear this statement, as well as the statement of policy adopted at the December meeting of The Council on Third Party Medical Care Plans.

Conference Suggested

The Council then considered a communication from Dr. Frank C. Sutton, chairman of the Professional Relations Committee of the Ohio Hospital Association. This letter recommended that the Ohio State Medical Association and the Ohio Hospital Association consider the possibility of amending the Medical Practice Act of Ohio so as to clarify the status of hospitals and certain specialists working in hospitals so far as the corporate practice of medicine is concerned.

By official action, The Council instructed the Judicial and Professional Relations Committee and the Committee on Hospital Relations to sit jointly with representatives of the Ohio Hospital Association for the purpose of considering the question raised by Dr. Sutton and any recommendations which might be forthcoming from the Ohio Hospital Association on this subject.

Ohio Society of Medical Assistants

The Council received a report regarding the Ohio Society of Medical Assistants from a special committee of The Council composed of Dr. George W. Petznick, Cleveland, chairman, Dr. Paul F. Orr, Perrysburg, and Dr. Carl A. Gustafson, Youngstown. The committee advised The Council that the Ohio Society of Medical Assistants, at a recent meeting in Hamilton, Ohio, had approved the Constitution and By-Laws, drafted by the special committee for consideration of that organization, with only two very minor changes.

Following a general discussion, by official action, **The Council voted its approval of the Ohio Society of Medical Assistants** and instructed the Executive Secretary to notify the officers of that Association accordingly.

Group Life Insurance Plan

The Council then considered reports from the special committee designated last year to present a group life insurance proposal, to be considered by The Council, for presentation to OSMA members. The special committee was composed of Dr. H. M. Clodfelter, chairman, Dr. C. C. Sherburne and Dr. R. E. Heering.

The committee presented a proposal which had been drafted by The Union Central Life Insurance Company and recommended its adoption. Also, the committee recommended that the insurance agency of Turner and Shepard, Columbus, be designated as official administrators of the plan.

By official action, The Council approved both recommendations of the special committee, (See page 926 this issue of *The Journal,*) and instructed the special committee to work out a mutually acceptable working agreement with Turner & Shepard for putting the program into effect at an early date.

Belmont County Case

A lengthy communication from Dr. Murray B. Hunter, Bellaire Clinic, Bellaire, Ohio, was considered. The communication alleged that the Belmont County Medical Society acted contrary to its constitution and by-laws in rejecting the applications for admission to membership of three Belmont County physicians.

Following a long discussion, **The Council instructed the Executive Secretary to advise Dr. Hunter** that it is the considered opinion of The Council that it does not have any jurisdiction to overrule or set aside the action of a component medical society, taken pursuant to its constitution and by-laws, in rejecting an applicant for membership; and that The Council found no evidence in the material submitted by Dr. Hunter to show that the Belmont County Medical Society acted illegally or otherwise under its own constitution and by-laws than in the proper exercise of its rights under its own constitution and by-laws.

Report of Committee on Medical Services

Dr. Charles L. Hudson, Cleveland, chairman of the Committee on Medical Services, was asked to report on a meeting of his committee held on Saturday afternoon, June 7. He reported as follows:

Medicare Program

A letter from Major General Robinson, Executive Director of the Medicare Program, dated March 11, was discussed by the committee. The

letter acknowledged a communication of March 7 sent to General Robinson advising him of the action of The Council, March 1, 1958, declining to sign a Medicare contract for the year 1958. It was ordered filed.

There was a general discussion of the Medicare situation nationally, including the Texas action in withdrawing from the Medicare Program; resolutions from various states to be introduced at the San Francisco AMA meeting; Congressional action to date limiting the amount of money for the Medicare Program, which may mean that more Medicare patients will have to be taken care of in military installations rather than by physicians in private practice. The committee felt that no action by the OSMA on these matters was necessary at this time.

VA Medical Program in Ohio

Reference was made to the fact that the new Veterans Administration medical setup in Ohio will take effect on July 1 and that the fee schedule suggested by the OSMA had been accepted by the VA with only three minor changes. Complete details on this will be published in the August *Journal*.

The committee was advised of a letter dated May 28 from the AMA Council on Medical Service to the AMA Committee on Federal Medical Services. The letter stated that perhaps certain VA tuberculosis hospitals would be declared "surplus" and that it might be that some of these institutions could be turned over to the state or local communities to be used as public hospitals—perhaps chronic disease hospitals. The committee was advised that this decision, if made, might pertain to the VA hospital at Brecksville, which is the only VA tuberculosis facility in Ohio. The committee instructed the Executive Secretary to refer this to the Cleveland Academy of Medicine for study and advice.

Fees Paid by Federal and State Agencies

The following letter from Dr. Arnoldus Goudsmit, Youngstown, President of the Ohio Society of Internal Medicine, dated February 7, was discussed:

"At the annual meeting of The Ohio Society of Internal Medicine held in Cleveland on January 22, 1958, we unanimously adopted the following resolution, and I was instructed to forward it to you for the attention of the Council of the Ohio State Medical Association. The resolution reads as follows:

'The Ohio Society of Internal Medicine is firmly convinced that whenever any agency of the Federal or State Government, or any other agency, assumes responsibility for the medical care of any group in our population, that such a group shall not be considered as medically indigent, and that fair and standard fees based on those usually assessed for professional services of similar quality for private and non-indigent patients be recognized as the acceptable basis for negotiations.'

"Kindly allow me a few words of explanation. In the past, agreements between state medical societies and agencies of government have been geared to the situation where semi-charity existed, or was supposed to be involved as one of the considerations. We believe that in the past circumstances and emergencies may have existed which made the acceptance of that type of fee structuring understandable.

"We believe that the time has come, and is here now, when the medical profession should stand up and point out to the governmental agencies concerned that they are not in the habit of asking any other group of workers or professional men to accept woefully sub-standard compensation for competent services rendered. In times past, due to the relatively small volume of that type of work carried out by any one practitioner, a sub-standard arrangement may not have provided a significant hardship on any one man. However, with the extension of government and private prepaid type of medical plans obviously increasing, this situation may not continue to exist much longer. We believe there is a special reason why the qualified internists of this State, of which this Society represents the sole means of verbalizing their problems, feel particularly strongly on this subject inasmuch as, in the past, the services provided by the internists have received, with few exceptions, most inadequate consideration.

"If so desired, I would be happy to further elucidate on the subject of this resolution and related material at your request, and at your convenience."

The committee instructed the Executive Secretary to advise Dr. Goudsmit that the principles outlined in the letter were in keeping with the general policy of the OSMA and undoubtedly would be taken into consideration by The Council in all future contacts with governmental agencies. The committee also stated that the letter should point out that the Association would welcome the advice and suggestions of the Ohio Society of Internal Medicine on all such matters.

Fees Paid Consultants at Columbus State Hospital

A letter from a Columbus physician was discussed by the committee and with Dr. Robert A. Haines, Director, Department of Mental Hygiene

and Correction, who attended the meeting for this purpose, on invitation of the committee. It pointed out the inequity of payments made to consultants serving the Columbus State School.

Dr. Haines pointed out that this problem arose primarily because of (1) a ruling by the State Auditor that physicians, to be on a part-time basis, must devote at least 20 hours per week in actual services in a state institution; and (2) inadequate funds to properly compensate physicians as consultants. Dr. Haines stated that it was not feasible to require so-called part-time physicians to actually put in 20 hours per week. In order to compensate such physicians in some other way an effort was made to place them in the consultant category. In doing so the Columbus State School ran into budget trouble.

There was considerable discussion as to ways and means of trying to remedy the situation as it was felt by all present that the present procedure of reimbursement is entirely inadequate and inequitable.

It was agreed that Dr. Haines would discuss this problem with the superintendents of the various state hospitals and state schools, and appear before this committee at a later date. He was asked particularly to present data at the next conference on the possibility of each institution having a special fund from which physicians, other than staff physicians, could be paid for services rendered; what amounts would be needed at each institution; what methods of compensating the physicians should be used, and whether or not it would be feasible to leave that matter entirely to the discretion of the superintendent of each institution.

Third Party Medical Care Plans

The committee discussed the question of third party medical care plans, especially the situation with respect to the United Mine Workers Welfare and Retirement Fund program. Reference was made to correspondence between the Executive Secretary and the Public Relations Department of the AMA on a proposed article in *Today's Health* written by a professional writer named "Herndon." The Executive Secretary was asked to send copies of this correspondence to members of the committee at his convenience.

The following letter from Dr. Warren F. Draper, Executive Medical Officer of the UMW program, in reply to a letter from the Executive Secretary dated May 14, which was accompanied by Resolution No. 12, adopted at the Cincinnati Annual Meeting, was read and discussed. The resolution asked that the UMW program be put on an indemnity basis.

"In reply to your letter of May 14, 1958, I must say that we are quite familiar with the principles of indemnity payments and know that neither the quality nor cost of services which beneficiaries would receive under a plan like this would be satisfactory to the Fund.

"A meeting of those concerned with Labor Health Services throughout the country will be held in Washington next month to consider the objectives which they have in common and the manner in which they may best be attained.

"The information and understanding resulting from this Conference may serve as a basis for better understanding on the part of all of those concerned as time goes on.

"Thank you for your courteous letter."

The committee felt that no action by the committee was necessary at this time.

The committee advised the Executive Secretary that it felt that no follow-up action would be necessary at this time with respect to Resolution No. 14, adopted at the recent Cincinnati Annual Meeting, as the situation complained of has been remedied.

Pathological Services

The committee felt that a copy of Resolution No. 1, adopted by the House of Delegates at the Cincinnati Annual Meeting, with an appropriate letter should be sent to Medical Mutual of Cleveland, and instructed the Executive Secretary to follow through on this.

Aid for the Aged Program in Ohio

A letter from Dr. F. C. Curtzwiler, Toledo, Secretary of the Ohio State Radiological Society, with respect to fees paid by the Division of Aid for the Aged for radiological procedures, was discussed. The committee felt that the Executive Secretary's letter to Dr. Curtzwiler in reply to his letter was satisfactory. It suggested that this letter be placed in the file of the new committee on problems of the aged, which would handle all matters with respect to the Division of Aid for the Aged medical care program in the future.

Correspondence from Mr. Edward F. Willenborg, Executive Secretary of the Cincinnati Academy of Medicine, with respect to correspondence between a physician and the Division of Aid for the Aged, was discussed.

The committee instructed the Executive Secretary to advise Mr. Willenborg, and for him in turn to advise the physician, that the solution to some of the questions in the correspondence hinges on more adequate appropriations for the program which would enable the Division to remove certain restrictions on the number of visits, etc.

At this point the committee engaged in a gen-

Dates and Places for Annual Meetings In Years 1959, 1960, 1961 and 1962

For the information of all members, and especially members or others who may have the responsibility of setting meeting dates for certain organizations, the following places and dates for future Annual Meetings of the Ohio State Medical Association will be valuable for reference:

1959 meeting . . . Columbus . . . April 21, 22, 23 and 24
1960 meeting . . . Cleveland . . . week of May 15
1961 meeting . . . Cincinnati . . . week of April 16
1962 meeting . . . Columbus . . . week of May 13

eral discussion with respect to the Division of Aid for the Aged medical care program. The committee instructed the Executive Secretary to discuss with Mr. Richard C. Minor, Assistant Director of the Ohio Department of Public Welfare, the possibility of a definite policy statement to the effect that a physician may look to a recipient of aid for the aged or his relatives, or anyone else, for part-payment for medical services in event the physician's customary fee for patients of this economic status is larger than the fee allowed under the Division's uniform fee schedule.

Reference was made to the report of the Governor's Commission on Aging, which among other things is recommending that the ceiling of $65.00 on Aid for the Aged pensions be eliminated and that more money be appropriated for the medical program.

Before adjourning the committee decided that it would be appropriate for the new Committee on Care of the Aged to take over all matters relating to the aged, including the Division of Aid for the Aged medical health care program, which up to this time have been handled by the Committee on Medical Services.

By official action, The Council approved the report presented by Dr. Hudson for the Committee on Medical Services.

Maternal Health

Mr. Page reported for the Committee on Maternal Health. He stated that the committee is planning an outline for a talk on "Guiding Principles for Obstetric Care" with slides and will encourage county medical societies to devote programs to maternal health using members of the committee. Also, it was reported that the committee is planning to produce an exhibit suitable for county and district medical meetings and the state meeting.

Resolutions Assigned to Committees

At the request of the Executive Secretary, The Council assigned to various committees certain resolutions adopted at the recent Cincinnati Annual Meeting, as follows:

Resolution No. 9, regarding aid for the aged, to the new Committee on Care of the Aged.

Resolution No. 11, regarding traffic safety, to the new Committee on Traffic Safety.

Resolution No. 13, regarding poison controls, to the new Committee on Poison Control.

Resolution No. 16, regarding the Hughes-Griswold Act, to the Committee on Public Relations and Economics.

Resolution No. 17, regarding medical care for migrant laborers, to the Committee on Public Relations and Economics.

Resolution No. 19, regarding a welfare and retirement plan for OSMA members, to the Committee on Auditing and Appropriations.

Mental Guidance Center

A communication from the Stark County Medical Society, asking for advice on the difference of opinion between the society and the Stark County Mental Guidance Center, was discussed. The Executive Secretary was requested to secure information from the Director of Mental Hygiene and then to write the Stark County Medical Society on the basis of the information obtained.

Chicago Pharmacal Proposal

Certain promotional material of the Chicago Pharmacal Company was discussed. This material included a proposal offering insurance against fetal mortality for any person using one of the company's drugs on a physician's prescription. It required the filling out of a form by the attending physician. The Council felt that this promotional material was improper; expressed the belief that perhaps the physician would be violating the Principles of Medical Ethics; and might be running the risk of being charged with the unlawful sale of insurance. The Executive Secretary was instructed

to express the views of The Council on this in an issue of the *OSMAgram.*

Letter of Thanks

A letter from the president of the Ohio Society of Internal Medicine, Dr. Arnoldus Goudsmit, Youngstown, thanking The Council for securing an upward adjustment of fees paid by the disability section of the Bureau of Vocational Rehabilitation, was read and ordered filed.

Traffic Safety Report

A communication from Dr. Drew L. Davies, reporting on the meeting of the President's Committee on Traffic Safety, held in Chicago on April 1 and 2, was ordered transmitted to the new Committee on Traffic Safety for its consideration and guidance.

By official action, The Council instructed the Executive Secretary to send a congratulatory letter on behalf of The Council to Dr. Arthur S. Flemming, President of Ohio Wesleyan University, concerning his appointment as secretary of the U. S. Department of Health, Education and Welfare.

Mr. Page was instructed to represent the Association on the advisory committee to the Ohio Association for Adult Education as requested by that organization.

Forand Bill

The President was authorized to send a letter to Ohio Congressmen at the time the Forand bill is up for a hearing, enumerating the steps being taken in Ohio to try to solve the problems of the aged and pointing out objections to the bill.

Pre-Election Conferences

Mr. Saville asked the advice of The Council as to the times and places for the usual pre-election conferences this coming Fall. Members of The Council approved the schedule as reported by him.

During the reports of Councilors, Dr. Elliott stated that representatives of the counties in the Third and Fourth Councilor Districts had decided that no meeting of the Northwestern Ohio Medical Society should be held this year. It was decided, he said, to hold a meeting in Findlay in the Fall of 1959, at which time an effort will be made to decide whether or not future meetings shall be held or the society dissolved.

Following reports by other Councilors on their districts, The Council adjourned to meet in Granville on September 12, 13 and 14, or sooner at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Study of Hospital - Medical Economics In Michigan

A comprehensive two-year study of Michigan's hospital and medical economics, under the direction of the University of Michigan, is under way.

The study was requested by the Governor's Commission on Prepaid and Medical Care Programs and will be financed by a $325,760 grant from the Kellogg Foundation.

The study will include the following:

1. A survey of hospitals, allied institutions, and agents in terms of services offered, general program, effectiveness of organization, and cost elements will be conducted to determine what health facilities and programs exist in Michigan which might logically fall within the realm of health insurance and prepayment, either on a service or indemnity basis.

2. Hospital and medical prepayment and insurance plans will be examined with specific reference to internal operation, costs, benefits, and contract limitations.

3. The relationships between contract benefits, availability of services, and use of benefits and services by patients will be studied.

4. The effectiveness of various proposals to control hospital and medical costs will be examined.

5. Hospital efficiency in terms of use of available facilities, timing of services, accounting, automation and substitute skills, medical staff organization, and regional planning will be investigated.

6. The problem of additional charges by physicians in respect to service contracts and the relationship, if any, between physician expenses to the patient and the extent of insurance coverage will be explored through interviews with patients and physicians.

7. A sample of the population with emphasis on the aged, retired, and disabled will be surveyed to determine its health experience, charges incurred, amount of insurance coverage, and current disability.

8. A study of Michigan Hospital Service and Michigan Medical Service (Blue Cross - Blue Shield) will be made specifically because of their size and breadth of program. This study will cover such factors as administration, accounting, benefits, enrollment and underwriting policies, rating principles, hospital relations, research and planning, reserves, service concept, and use of services. In Michigan Medical Service only, fee schedules and the characteristics of participating and nonparticipating physicians will also be analyzed.

STATEMENT OF THE COUNCIL

Of the Ohio State Medical Association

Regarding Unauthorized Practice of Medicine by Partnerships, Associations, Institutions, Corporations, Unlicensed Persons And the Ethical Status of Physicians Involved

ON May 16, 1957 the House of Delegates of the Ohio State Medical Association adopted the following resolution:

"WHEREAS, there have been controversies in the United States and the State of Ohio on the corporate practice of medicine and,

"WHEREAS, the definition of the corporate practice of medicine has not been defined by the Ohio State Medical Association,

"BE IT RESOLVED, that the Ohio State Medical Association adopt a definition of the corporate practice of medicine for uniform application throughout the State of Ohio."

With a view of complying fully with the mandate expressed in this resolution, The Council referred this matter to the Judicial and Professional Relations Committee and the Committee on Hospital Relations for study and report. These committees have held numerous meetings during the past year with various specialists in the practice of medicine and with other groups and organizations vitally interested in the questions involved, including representatives of the Ohio Hospital Association, in order that all sides and phases of the question of corporate practice of medicine, and closely related subjects, might be fully and fairly explored and considered.

The two committees submitted a report to The Council of the Ohio State Medical Association in mid-May, 1958.

On June 8, 1958, The Council, in official session in Columbus, voted unanimous approval of the report, the complete text of which follows:

* * *

Text of Report

While the term "corporate practice of medicine" used in the strict sense refers only to the unauthorized practice of medicine by corporations whether organized for "profit" or "not for profit") the term has been quite commonly understood as connoting the unauthorized practice of medicine by a partnership, association, institution (charitable or non-charitable), corporation (profit or non-profit) or unlicensed person, through the agency of a duly licensed physician. Believing that the House of Delegates intended the development of a definition which would embrace all forms of unauthorized practice of medicine through the agency of a duly licensed physician, and which would be of assistance in the determination of the ethical status of physicians engaged in the practice of medicine under a contract or contracts with lay organizations, the Judicial and Professional Relations Committee and the Committee on Hospital Relations approached the problem with these objectives in mind.

A thorough understanding of the basic reasons for the long established rule forbidding what is popularly known as "corporate practice" is very essential to the proper understanding of the rule itself and to the determination of what activities lie within, and what activities lie without, its orbit. The ascertainment of these basic reasons, and the problem of developing a clear, understandable and workable definition have necessitated a careful examination of the legal pronouncements on the subject of corporate practice, as well as the ethical pronouncements of the American Medical Association and of this Association on the same subject. We shall, therefore, proceed to review some of the pertinent pronouncements of the legal authorities and of the AMA and the OSMA on the subject.

Allison Case

One of the leading court cases explaining the basic reasons for the rule forbidding the "corporate practice of medicine" is that of *Dr. Allison Dentist, Inc. vs. Allison,* 196 N. E. Rep. 799, decided by the Supreme Court of Illinois about 20 years ago.

In holding that the corporation could not lawfully engage in the practice of medicine the Court said:

"The practice of a profession is everywhere held to be subject to licensing and regulation under the police power and not subject to commercialization or exploitation. * * To practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being and to qualify something more than mere knowledge or skill is essential. The qualifications include personal characteristics, such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients even to the extent of sacrificing pecuniary profit if necessary. These requirements are spoken of generically as that good moral character which is a prerequisite to the licensing of any professional man. No corporation can qualify. It can have neither honesty nor conscience and its loyalty must, in the very nature of its being, be yielded to its managing officers, its directors and its stockholders. Its employees must owe their first allegiance to their corporate employer and cannot give the patient anything better than a secondary or divided loyalty." ** (Citation of court decisions omitted).

Ohio Attorney General Opinion

In Opinion No. 1751 of the Attorney General of Ohio, rendered on August 20, 1952, the Attorney General called attention to the fact that Section 8623-3 of the General Code of Ohio (now Revised Code Section 1701.04) prohibits the corporate practice of a profession, and he reviewed various Ohio court decisions holding that a corporation may not engage in the practice of optometry or law. In holding that the prohibition contained in the statute, and the principles announced in the Ohio court decisions, applied to medicine as fully as to optometry and law, the Attorney General made this significant statement:

"In view of the emphasis in the Ohio decisions on good moral character as a requirement of practitioners of a profession, we must conclude that the courts regard the preservation of such requirement as the principal legislative objective of the prohibition in Section 8623-3, supra, of the corporate practice of a profession. In this view of the matter it would appear that the General Assembly entertained the notion that corporations, as impersonal entities, are amoral in character, and could not be relied upon to adhere to the canons of ethics which obtain in the several professions, especially in instances where control of the activities of the corporation is vested in individuals not licensed in the profession concerned. Accordingly, such being the legislative purpose and policy, I am wholly unable to perceive the logic of any interpretation of the 'sanitarium provision' in Section 8623-3, supra, which would permit corporations generally to engage in the practice of medicine, while at the same time all of the other professions are strictly guarded against invasion by corporate practitioners. I am the more inclined to this view for the reason, commonly recognized in both lay and professional circles, that in no profession recognized by the law as such is there a greater need for professional ethical standards of the highest sort than in the field of medicine."

AMA Principles of Medical Ethics

Justification for the rule forbidding associations, institutions, and corporations to practice medicine will also be found in the Principles of Medical Ethics and in the pronouncements of the Judicial Council of the AMA relative to the ethical factor involved in the participation by a duly licensed physician in certain types of contract practice. The 1957 Principles of Medical Ethics contain no definition of "contract practice" and make no express reference to such term. However, the Judicial Council of the AMA has expressed the opinion that Section 6 of the 1957 Principles embraces the spirit and intent of Chapter VII, Sections 3 and 5 of the 1955 edition of the Principles of Medical Ethics relating to contract practice; these Sections are as follows:

Section 6 (1957 edition):

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Section 3 (1955 edition):

"Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary, or for a fixed rate per capita.

"Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deteriora-

tion of the quality of the medical services rendered."

Section 5 (1955 edition):

"A physician should not dispose of his professional attainments or services to any hospital, lay body, organizations, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

Opinions of Judicial Council

The following are excerpts from Opinions and Reports of the Judicial Council of the AMA which are applicable in the interpretation of the above-quoted Principles of Medical Ethics:

"When a physician signs a contract with a commercial organization to make physical exabinations of all persons sent to him by the organization for a price set by the organization, and allows that organization to make its own charge to the individuals examined for the services rendered by the physician, the physician is selling his independence to the jobber.

"* * *

"Individualism in the practice of medicine is essential to success if one had in mind the interest of the patient and the encouragement of medical progress. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient. We cannot help but feel that the service of periodic health examinations, as conducted by commercial institutions, must inevitably result in the undermining of the confidence of the people in the ability of the practitioner." (1924 Report)

"The Judicial Council desires to express again its firm conviction that the benefits of scientific medicine cannot be adequately delivered to the individual through the medium of a third party, and that the communication of results of physical examination and the general advice with which it should be associated should go directly from the individual physician to his patients. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient." (1925 Report)

"It has been brought to the attention of the Judicial Council that some hospitals have adopted rules whereby attending staff physicians are prohibited, under certain conditions, from accepting fees for professional services, though charges for such services are made and fees are collected and appropriated to their own use by these hospitals. In one instance, members of a hospital staff were prohibited from the collection of fees for services rendered to certain ward patients, who were required to pay for hospital accommodations and to pay for service rendered by members of its staff, the hospital retaining all money collected for its own use. The Judicial Council gave its opinion to the effect that such procedure on the part of a hospital is unethical." (1929 Report)

"With regard to the practice of medicine by corporations, it is the opinion of the Judicial Council, that such practice is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served." (1930 Report)

"The privilege of healing the sick as a profession is a right granted only to those properly qualified and licensed by the state. It is a privilege belonging only to the medical profession. It is a sacrifice of professional dignity that this exclusive right of medicine is so often sold for individual gain or its possessor deprived of it against his will. In increasing numbers, physicians are disposing of their professional attainments to lay organizations under terms which permits a direct profit from the fees or salaries paid for their services to accrue to the lay bodies employing them. Such a procedure is absolutely destructive of that personal responsibility and relationship which is essential to the best interests of the patient.

"Outstanding examples of this type of unearned gain are not difficult to find. There are insurance companies administering workmen's compensation benefits wherein the salaries or fees paid to the physician by the insurance company are so much below the legal fees on which the premium paid by the industry is based as to furnish a large direct profit to the insurance company. Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to 'house cases' but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full time hospital staffs and opening

their doors to the general public, charging such fees for the professional care of the patients as to net the university no small profit, are in direct and unethical competition with the profession at large and their own graduates. They are making a direct profit by a practice of questionable legality, from the professional care." (1932 Report)

"Many forces are pressing for the adoption of new methods of medical practice and for changes in the relations of physicians, as indidividuals and as organized groups, toward the public and toward institutions and organizations, and also for revolutionary changes in the very traditions of the profession with respect to the obligations and privileges of physicians in their contacts with one another. These forces have in some instances been sadly misdirected and will result in disaster to medicine and to the public.

"The complexities of modern society may make it imperative that some changes shall be made, but the duty of the organized profession is to see to it that any and all proposals for change, from whatever source, shall be scrupulously and deliberately examined with the view of determining their ultimate value. Decisions should not be made on the basis of feasibility for the immediate present but should be made in the light of the experience of the profession, the nature of its service, the imperative need for maintaining professionalism and the absolute necessity for unhampered scientific advancement, and with the utmost regard for the best interest of the people." (1932 Report)

Section 7 of Principles

Section 7 of the 1957 Principles of Medical Ethics reads:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

The Judicial Council has expressed the opinion that Section 7 embraces the spirit and intent of Chapter I, Section 6, of the 1955 edition of the Principles; Section 6 of Chapter I reads as follows:

"The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered or in the form of a subsequent statement.

"Unethical methods of inducement to refer patients are devices employed in a system of patronage and reward. They are practiced only by unethical physicians and often utilize deception and coercion. They may consist of the division of a fee collected by one physician ostensibly for services rendered by him and divided with the referring physician or physicians or of receiving the entire fee in alternate cases.

"When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, 'kickbacks,' discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.

"Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor-patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care."

Opinions on Section 7

The following are excerpts from the Opinions and Reports of the Judicial Council of the AMA, which are applicable in the interpretation of Section 7 of the 1957 Principles:

"There have been widespread inquiries and complaints concerning the practice of medicine by hospitals, the division of fees between hospitals and doctors, the acceptance of commissions or rebates by ophthalmologists from opticians, the extensive unethical instances of contract practice particularly in the Pacific Coast states. Concerning all of these matters it is sufficient to say that wide extent of an unethical practice does not make it ethical. Ethics has to do with principles, not numbers or locality. A procedure unthical in one part of the country cannot be ethical under the same circumstances in another. * * *

The Judicial Council deplores such ignoring of ethical principles, not only because of the extent of the practice but because in many instances the pleas of the financial necessity cannot be offered as an excuse. The Council can only publicize the abuses and express its severe condemnation of them. It has no power in itself of control or correction." (1934 Report)

"The suggestion has been made by some hospitals that physicians who utilize the hospital facilities should pay to the hospital a percentage of the fees which they receive from their patients while being cared for in the hospital.

"The Council has many times expressed itself on the subject of fee splitting. The suggested proposal is clearly a case of splitting or sharing professional fees with a lay organization which should not render professional service in the first place, but which, in addition, has already levied its regular bill for the services which it legitimately rendered." (1952 Report)

OSMA Policy Statement in 1943

The following Statement of Policy was adopted by The Council of the OSMA on October 3, 1943:

"If a hospital, a corporation, employs a physician at a fixed stipend or on a commission or percentage basis and charges and collects a fee for his professional services and retains the amount collected, regardless of whether the hospital profits or loses under such an arrangement, we are of the opinion:

"1. That an agency relationship exists between the hospital and such physician and that the familiar legal doctrine of *respondeat superior* applies, meaning that the hospital (a corporation) is responsible for the acts of such physician (its agent) and therefore is liable for the torts (wrongful acts) of the physician;

"2. That the hospital (a corporation) is itself engaged in the practice of medicine, as the hospital occupies the position of principal in an agency relationship involving the practice of medicine and, therefore, falls within the purview of the general rules of agency which establish the proposition that the principal, in effect, performs those acts which are performed by the agent;

"3. That, inasmuch as the practice of medicine by a corporation is unlawful under Ohio statutes, the hospital cannot legally practice medicine directly or **indirectly by means of an agent,** even though such agent may be a duly licensed physician;

"4. That it is unethical and unprofessional in accordance with the provisions of Article 6 of the Principles of Medical Ethics of the American Medical Association relating to contract practice for a physician to enter into an arrangement as described.

"The foregoing conclusions on the legal questions involved are based on numerous court decisions and legal opinions wherein the weight of the evidence, judicial reasoning and statutory authority favors the interpretations herein set forth.

"Some may argue that unlawful and unethical practices such as those referred to are being carried on in various communities and that no steps have been taken to stop or prevent them.

"Be that as it may, the fact that such unlawful and unethical practices are occurring, seemingly without interference, does not make such practices lawful or ethical.

"Legal processes are available to put an end to such unlawful acts on the part of a corporation and to revoke the license of a physician involved in the unlawful acts of the corporation. Ample authority is vested in a local medical society to invoke disciplinary action for violations of the principles of medical ethics on the part of a member.

"The foregong statements with respect to unlawful and unethical acts do not apply to an arrangement whereby a hospital, with the consent of a physician, undertakes to collect fees **on the account** of the physician for services rendered by him in the hospital and when the patient is notified of the amount of the professional charges and is informed that the physician's fees are being collected by the hospital in his name and for him."

Statement on Physicians and Hospitals

In the Joint Statement of Basic Principles for Ohio Physicians and Ohio Hospitals, formulated by the Committee on Hospital Relations of the OSMA and the Committee on Professional Relations of the Ohio Hospital Association appears the following basic principle:

"4. The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the policy of professional incentive for the physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organizations, group, or individual, by whatever name called, or however organized, under terms or

conditions which permit exploitation of the patient, the hospital, or the physician."

Reference to Attorney General Opinion

In Opinion No. 1751 of the Attorney General of Ohio, referred to above, at pages 2 and 3, the Attorney General made the following rulings:

"1. A corporation, whether or not organized for profit, may not lawfully engage in the practice of medicine in this state.

"* * *

"4. A hospital corporation, whether or not organized for profit, is entitled to a fair compensation (a) for the use of technical equipment owned by it and used by a physician in the performance of professional services, and (b) for non-professional services supplied to such physician; but where such corporation enters into an arrangement with a physician whereby it receives compensation for such use and such services which is manifestly in excess of the fair value thereof, the hospital is unlawfully engaged in the practice of medicine and the physician concerned is guilty of grossly unprofessional conduct under the provisions of Section 1275, General Code."

In the course of this opinion the Attorney General said:

"In view of these clear expressions of the law, I am bound to conclude that in this state corporations, whether or not organized and operated for profit, may not practice a profession indirectly by hiring licensed members of such profession to do the actual professional work involved."

Opinion on Interns and Residents

Shortly after the issuance of Opinion No. 1751 the Ohio State Medical Board made inquiry of the Attorney General as to whether Opinion No. 1751 should be construed as forbidding, or as rendering unlawful, the employment by hospitals of interns or residents. In answer to this inquiry, the Attorney General of Ohio issued, on October 14, 1952, his Opinion No. 1961 in which he held as follows:

"Where graduate physicians are employed as interns or residents by a hospital under an arrangement whereby such employees (1) give medical and surgical treatment to charity patients under the supervision of hospital staff physicians, (2) give emergency medical and surgical treatment to any patient requiring it, even in the absence of the attending physician, and (3) in partial compensation for such services, such employees are permitted to receive instruction in medical and surgical practice from the several hospital staff physicians, during the course of which instruction they assist such staff physicians in the treatment of all types of patients, the hospital-employer is not engaged in the practice of medicine as defined in Sections 1286 and 1287, General Code (now Revised Code Sections 4731.34 and 4731.36)."

Opinion on Practice of Dentistry

In another opinion by the Ohio Attorney General in 1952, (Opinion No. 1717) the Attorney General issued the following pronouncements with respect to the practice of dentistry which seemingly would apply with equal force to the practice of medicine by an association, institution or corporation:

"A parent-teacher association may employ a licensed dentist to operate a dental clinic on a purely charitable basis; but the operation of a dental clinic by such association under an arrangement whereby fees are charged and paid to the association for professional services rendered by a licensed dentist as an employee of such association would amount to a violation of Section 1320, General Code.

"A corporation, whether or not partially supported by a local community Fund, is not authorized to engage in the practice of dentistry; and such corporation would be unlawfully engaged in the practice of dentistry where it has undertaken to operate a dental clinic by utilizing the professional services of licensed dentists and to charge and collect a fee for such professional services.

"Under the provisions of Section 1329, General Code, a licensed dentist may not lawfully accept employment from a corporation or association of persons not licensed as dentists under the terms of which employment such employee performs professional dental services for which such corporation or association charges and collects a fee."

So far as The Council has been able to determine there have been no later opinions of the Ohio Attorney General which conflict with, or modify, the above Opinions Nos. 1717, 1751, and 1961.

Summary

Keeping in mind (a) the foregoing basic reasons for the general rule forbidding the unauthorized practice of medicine by partnerships, associations, institutions, corporations and unlicensed persons, (b) the provisions of the Principles of Medical Ethics, (c) the foregoing pronouncements of the AMA and of this Association, and (d) the

opinions of the courts of Ohio and of the office of the Ohio Attorney General with respect to the practice of a profession by an association, institution or corporation, The Council has formulated a definition of the unauthorized practice of medicine which it hopes and believes will be of help to the component county medical societies and to all Ohio physicians in determining whether under a given set of facts there exists the unauthorized practice of medicine by a partnership, association, institution, corporation or lay person, and in determining whether under such facts any physician has been guilty of an unethical act in aiding or abetting, or participating in, any unauthorized practice as may be found to exist.

Conclusions

It is the opinion of The Council of the Ohio State Medical Association that the unauthorized practice of medicine occurs when a partnership (other than a partnership composed solely and exclusively of physicians), an association, an institution (charitable or non-charitable), a corporation (profit or non-profit), or an unlicensed person purveys or furnishes, or contracts or offers to purvey or furnish, the professional services of a duly licensed physician under terms, conditions, or circumstances whereby such partnership, association, institution, corporation or unlicensed person:

(1) directly or indirectly makes its or his own charge to the patient (or to any other person, partnership, association, institution or corporation claimed to be liable for the obligations of the patient) for the professional services performed by such licensed physician; or

(2) directly or indirectly obtains or retains the whole or any part of the charge or fee paid for such professional services, whether such professional charge or fee is separately billed or paid, or is included in the total charge billed by, or paid to, such partnership, association, institution, corporation or unlicensed person; or

(3) directly or indirectly participates in the division or sharing of the whole or any part of any professional fee or fees of such licensed physician; or

(4) receives payment or compensation in any form for, or derives any pecuniary gain, reward, or benefit from, the performance of the professional services of such licensed physician;

and any licensed physician who is a party to, or who aids or abets, such unauthorized practice of medicine thereby subjects himself to the charge of violating the Principles of Medical Ethics and also of violating the Ohio Medical Practice Act (Ohio Revised Code Section 4731.22).

Dr. Hudson Cited for Outstanding Service to His Community

At its annual meeting on May 16, the Academy of Medicine of Cleveland honored Charles L. Hudson, M. D., in recognition of his outstanding services to his community and the Academy of Medicine. Dr. Hudson is a Past-President of both the Academy of Medicine of Cleveland and the Ohio State Medical Association. He was awarded the following certificate:

"The Academy of Medicine of Cleveland and the Cuyahoga County Medical Society recognizes Charles Lowell Hudson, M. D., for distinguished service to the medical profession and to the community."

(Signed) Thomas D. Kinney, M. D.
President
May 16, 1958

Sixth Councilor District Schedules Postgraduate Day October 22

The Sixth Councilor District Postgraduate Day, which has met with much enthusiasm in recent years, has been scheduled for Wednesday, October 22, in Akron, Dr. Carl A. Gustafson, District Councilor, announced.

The program will consist primarily of panel discussions with sections on pediatrics, medicine, surgery and obstetrics-gynecology. So far more than 15 speakers have been contacted and have agreed to participate. All are professors in or chairmen of their respective departments in medical schools. Approximately six additional speakers have been invited and the committee is awaiting their replies.

Plans call for panels to be in session for the greater part of the day, several sessions running concurrently.

The committee on arrangements promises that this will be one of the finest programs sponsored by the Sixth District. Details will be announced later.

Chest Physicians' Pamphlet Outlines Chemotherapy

"Chemotherapy of Specific Infectious Diseases of the Lower Respiratory Tract," is the title of a pamphlet reprint from *Diseases of the Chest,* journal of the American College of Chest Physicians. The text is a report of the Committee on Chemotherapy and Antibiotics of that organization. Medical organizations or physicians interested in securing copies are invited to contact Maurice G. Buckles, M. D., 1 South Fourth St., Columbus 15.

You and Your Public . . .

Mutual Understanding of Fee Helps Maintain Good Physician-Patient Relationship

The doctor who feels he need not concern himself with the business side of his practice should ask himself:

"What if my patients felt the same way; what if they felt the matter of paying their fees is trivial?"

One of the biggest public relations problems the physician faces today is the business side of his practice. The need for concerning himself with this side of his practice is ably developed in an article in the March issue of *The Cincinnati Journal of Medicine,* written by Dr. I. C. Sharon, *Journal* public relations editor.

Dr. Sharon brings out the crux of the entire fee question by stating, "Failure of the patient to pay a medical fee is a symptom and the wise doctor will look for underlying causes. Turning an unpaid account over to a collector may be an easy way to dispose of it, but in most cases this signifies that the doctor's office has been remiss somewhere in the relationship with the patient."

Office Policies Important

If the doctor's office is remiss, then the doctor is remiss, for he should establish for his office staff policies for the staff to follow, and make certain that his policies are followed.

When the patient receives a statement, he does not think of it impersonally as a statement from the physician's office, but rather from the physician himself.

Dr. Sharon writes: "As in all other phases of medicine, prevention here is the best policy. Once there are standardized fees the physician or his assistant can tell the patient on his first or second visit what the usual charges are. In fact, when the secretary obtains the customary information in the patient's record, she might ask, 'Would you like to know what our usual charges are?' The doctor should be alerted if the patient answers that he doesn't care to know.

"Actually, aside from preventing future collection trouble, one learns much of the patient's psychological eccentricities. This preliminary discussion with the patient, usually by the assistant, follows along natural lines and not only provides much useful social service information but also defines the economic pattern for all future doctor-patient contacts.

Practical Planning Is Key

"The doctor who knows of the marginal economic case or the medical indigent case can start over-all medical planning in a practical way at the very beginning of his contact with the patient. This realistic approach prevents future embarrassment to the patient, minimizes bookkeeping in the doctor's office, and often avoids future financial prostration of the patient and his family."

Dr. Sharon presents two very relative questions to ask the person who seeks a reduced fee. One is, "Do you feel that the charge is excessive?" If the patient does not feel it is in excess, the question which follows is, "Will payment of this fee affect your standard of living within the next six months?"

These questions bring up the basic issues diplomatically, and usually develop information the physician needs to evaluate the person's ability to pay. These questions are far more tactful than a blunt "how much money do you make?"

Even after sincere efforts to reconcile a fee dispute fail, there remains a tactful path for the doctor to follow. He can suggest that the patient discuss the matter objectively with some thinking person, or with the local medical society, and at the same time he can courteously but firmly maintain his contention that the patient is being charged a reasonable fee.

Dr. Sharon concludes, "Gimmicks should not be a part of the economic aspect of the practice of medicine. Their employment lowers the dignity of the medical profession and endangers feelings of distrust and suspicion toward doctors. The practice of charging more than the doctor ordinarily expects to get, with the intent of abruptly reducing the fee if the patient complains, is unbecoming to one in the medical profession.

Need Determines Visits

"Scheduling of repeated visits in excess of what the doctor feels is required for good therapy is certainly disreputable. The use of placebos, injections, and other methods which the doctor knows are not to the patient's best welfare over the long term is deplorable.

"There should be no secrecy about lowering a fee if the circumstances warrant it. The doctor brings about disrespect for himself when he lowers a fee and then tells the patient not to mention this to anyone else. Reducing a fee only to a

minor degree generally accomplishes nothing and encourages future bargaining.

"The more the doctor is able to practice sound, objective medicine, and this is determined by his psychological needs and economic pressures, the less he will need to employ gimmicks in his daily practice. What is to the best interest of the patient in the long run should determine his fees as well as his therapy. What is to the best interest to the patient is eventually best for the doctor, for the medical profession, and for society."

License Over 7,000 New Physicians in U. S.

For the fifth consecutive year more than 7,000 new physicians entered the practice of medicine in the United States during 1957.

This was revealed in the 56th annual report of the American Medical Association's Council on Medical Education and Hospitals which appears in the May 31 *Journal of the American Medical Association.*

In Ohio, the State Medical Board issued licenses to 423 graduates in medicine by examination and 318 by endorsement. The Ohio board also issued licenses to 78 osteopaths by examination and six by endorsement.

Nationally, of the 7,455 new doctors licensed to practice, 5,872 licenses were given as a result of written examination and 1,583 by interstate reciprocity or endorsement of credentials.

During the same period, 3,500 physician deaths were reported, which reduces the over-all gain in the doctor population to 3,955.

In all, state and territorial boards issued 15,090 licenses during the year but 7,635 went to doctors already holding licenses from another state or to men who took examinations in more than one state.

The total number of licenses issued, both by written examination and reciprocity or endorsement of credentials, represents an increase of 547 over 1956.

In issuing 2,167 licenses, California led all other states. New York was second with 1,355, while Ohio and Pennsylvania were next with 831 and 741 licenses respectively. Florida, Illinois, Maryland, and Texas each had in excess of 500. Nevada, with 15, licensed the fewest number of doctors.

During the year there were 9,116 applicants for licensure by written examination. Of these, 7,769 passed and 1,347 failed.

Three medical schools had graduates for the first time during the period. They were the University of Missouri, University of Saskatechwan, and the University of Mississippi. All of the graduates of the Mississippi school passed their written examinations.

The graduates of foreign faculties of medicine include both American and foreign born and the 1,345 who passed the examination represent an increase of 333 successful candidates over 1956.

Have You Reregistered Under Harrison Narcotics Act?

The Narcotics Division of the Federal Internal Revenue Service has mailed to physicians on its record the proper forms for reregistering under the Harrison Narcotics Act. Initial application for registration by the physician may be made at any time, but existing permits must be renewed each year before July 1. The fee is $1.

Physicians who have not reregistered are urged to do so immediately.

Physicians who administer, dispense or prescribe cannabis must obtain a special permit under the Marihuaha Tax Act and pay an additional tax of $1.

Report Projects 1970 Need for Registered Nurses in Ohio

Ohio will have to increase its number of registered nurses by 36,000 by 1970 in order to meet National League for Nursing standards for the population anticipated by that year, according to a report of the Division of Nursing, Ohio Department of Health.

The report revealed that the current ratio of nurses per 100,000 population in Ohio is 232, while the NLN has recommended that the ratio be increased to 300-350 per 100,000 population. By 1970, Ohio's population is expected to increase 28 per cent.

"In the 62 schools of nursing in Ohio in 1956, enrollments reached 6,300. From 1951 to 1956 (the enrollment) increased one-tenth of one per cent each year. If this rate of increase in proportion continues, enrollments can be expected to reach 12,000 by 1965—17,000 by 1970," the report states.

It also points out that the number of college age students considered potential candidates for enrollment in schools of nursing (190,000 in 1955) is expected to reach 375,000 in 1970.

The report was based on information obtained from 288 general hospitals, 125 nursing homes, 22 hospitals of the Department of Mental Hygiene and Correction, 62 professional schools and 16 practical schools of nursing.

Science Writing Workshop . . .

Representatives of the Medical Profession and Writers Interested in Medicine Get Together in Cincinnati at Jointly Sponsored Conference

MEDICINE has a story to tell, news media wants to tell the story, and the public wants to know the story. That was the consensus of participants in the Regional Science Writing Workshop in Cincinnati May 22 jointly sponsored by the AMA and the National Association of Science Writers.

And they agreed that mutual cooperation between physicians and science writers is bringing to the public accurate, informative and reliable medical news.

It further was pointed out that in almost every case where a medical story is not accurate or in good taste, there can be found a lack of cooperation either on the part of the writer, the physician or medical group, or both.

Both the science writers and the physicians asserted that cooperation has produced an understanding of "the other fellow's problem" and a greater respect and appreciation of his profession.

Ohioans on the program included Dr. George A. Woodhouse, Pleasant Hill, OSMA President; Dr. Charles L. Hudson, Cleveland, a past-president; Dr. J. Robert Hudson, president-elect, Cincinnati Academy of Medicine; Dr. Frank P. Cleveland, University of Cincinnati College of Medicine;

Dr. Lloyd Larrick, superintendent, Christ Hospital, Cincinnati; Dr. John B. Chewning, director of professional relations, Wm. S. Merrill Co., Cincinnati; Bernard C. Wexler, Ph. D., May Institute for Medical Research, Cincinnati; Dr. Benjamin F. Miller, director of medical research, May Institute; Mr. George H. Saville, OSMA director of Public Relations; Dr. George Schwemlein, editor, *Cincinnati Journal of Medicine;* Edward F. Willenborg, executive secretary, Cincinnati Academy of Medicine; Don Dunham, science editor, *The Cleveland Press;* James Golden, Jr., science editor, *The Cincinnati Enquirer.*

Also attending the workshop were Hart F. Page, assistant director of public relations, OSMA; Charles W. Edgar, administrative assistant, OSMA; Oliver W. Brown, Jr., *Dayton Daily News;* Kenneth F. Cole, city editor, *Akron Beacon Journal;* William B. Collins, reporter, *Cincinnati Enquirer;* Grant A. Drennen, Columbus Hospital Federation;

Rober W. Elwell, executive secretary, Toledo Academy of Medicine; R. F. Freeman, executive secretary, and Kenneth C. Evans, assistant executive secretary, Montgomery County Medical Society; Karl T. Finn, assistant to publisher, *Cincinnati Times-Star;* Mrs. Margaret K. Fischer, assistant public relations manager, Jewish Hospital Association, Cincinnati; James Hunkler, public relations manager, Battelle Memorial Institute, Columbus; Kornel Huvos, *Times-Star;* Mary McGarey, science writer, *Columbus Dispatch;* Sharon Moloney, science writer, *Cincinnati Post;* S. H. Mountcastle, executive secretary, Summit County Medical Society;

Louis J. Pansky and Eugene R. Porter, Cincinnati Health Department; Katherine Sullivan, science writer, *Columbus Citizen;* Glenn Thompson, executive editor, *Cincinnati Enquirer;* Richard Thornburg, editor, *Cincinnati Post,* and William Webb, executive secretary, Columbus Academy of Medicine.

The workshop also was attended by science writers from Michigan, Indiana and Kentucky.

Arrangements for the workshop were conducted by John L. Bach, director of the press relations section, Department of Public Relations, AMA, and members of his staff. It was the second in a series of workshops, the first being held in Syracuse, N. Y., and three additional sessions planned in other parts of the nation.

Grant Promotes Study in Genetics At Western Reserve

A grant of $317,165 for a genetic study headed by Dr. Arthur G. Steinberg of Western Reserve University became effective June 1.

The grant, made by the National Heart Institute of the National Institutes of Health, will be paid over a five-year period. It will be used for a study of a religious community of about 10,000 and its records which have been carefully kept for more than 100 years.

The study will include data on diet, the relationship between cholesterol and coronary disease, the incidence of diabetes, the role of heredity in the relationship of blood groups and their effect on fertility and sex ratio, and the incidence of gene mutation.

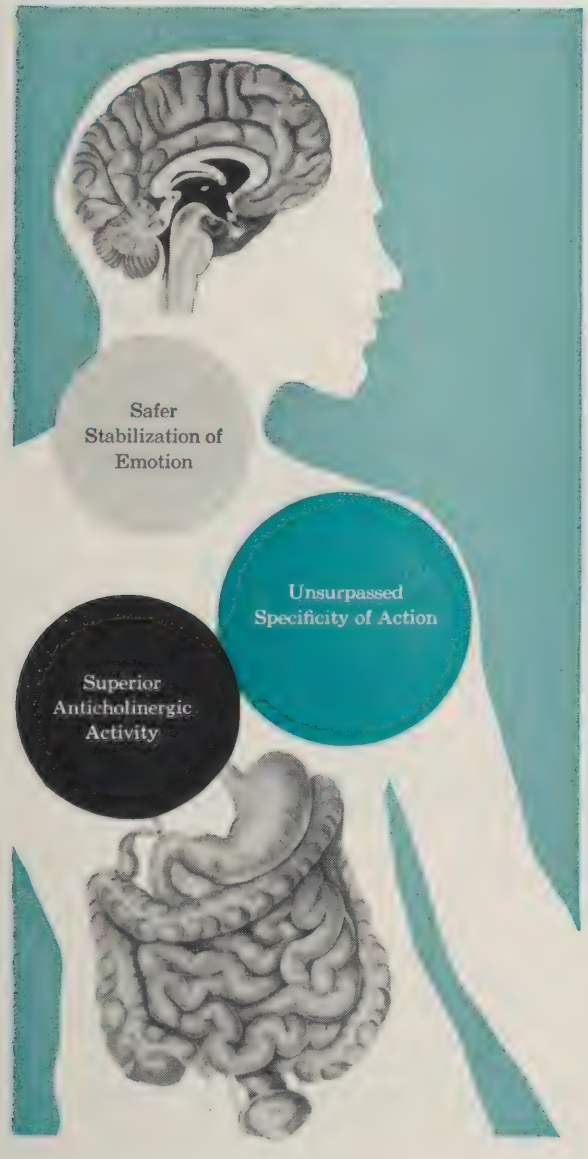
Dr. Walter H. Pritchard, associate professor of medicine, has been designated to assist Dr. Steinberg. The latter is professor of biology and assistant professor of genetics in the department of preventive medicine.

Controls Stress

Relieves Distress in smooth muscle spasm

new Pro-Banthine® *with* Dartal®

— for positive relief of cholinergic spasm. — a new and safer agent for normalizing emotions.



PRO-BANTHINE WITH DARTAL offers you a new, specific and reliable control of visceral motor disorders, especially when these disorders are induced or aggravated by psychic tensions or anxiety.

Pro-Banthine has won wide clinical acceptance as the most effective drug for controlling gastrointestinal hypermotility and hypersecretion.

Dartal, a new phenothiazine congener, offers greater safety, flexibility and effectiveness in stabilizing emotional agitation.

The combination of each drug in fully effective doses in Pro-Banthine with Dartal gives a new means of approach to the medical management of functional gastrointestinal disorders mediated by the parasympathetic nervous system.

Specific Clinical Applications: Functional gastrointestinal disturbances, gastritis, pylorospasm, peptic ulcer, spastic colon (irritable bowel), biliary dyskinesia.

Dosage: One tablet three times a day.

Availability: Aqua-colored tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).

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SEARLE

New Medicare Policy on Drugs . . .

The Government Agency Will Pay for Drugs Administered Parenterally, But Will Not Be Responsible for Oral Medication Dispensed or Prescribed

A NEW POLICY regarding the furnishing of drugs by physicians and payment for them under the Medicare Program was issued on May 29 by the Office of Dependents Medical Care, Washington. The new policy which will become effective July 1 is as follows:

Payment for oral medication dispensed or prescribed by physicians providing care authorized under the Medicare Program to eligible dependents will be the responsibility of the patient or sponsor and will not be compensable to physicians under the Medicare Program.

Payment for Drugs Amended

Physicians furnishing authorized care to eligible dependents under the provisions of the Dependents' Medical Care Act may include the cost to them of those drugs which they administer parenterally, provided such drugs are necessary and directly related to the condition for which authorized care and treatment are being furnished.

In order for a physician to obtain reimbursement for any drug administered parenterally, he must identify the nomenclature and quantity of the drug and set forth the cost thereof to him on the Claim Form or attachment thereto. No service or breakage charge is payable.

The physician's statement as to the cost to him of drugs parenterally administered, for which reimbursement is requested, may be accepted by Fiscal Administrators without question unless, during the review of the claim involved, it appears the charge indicated thereon is not in conformity with other charges for similar drugs. It is recognized that errors may be made in billings for drugs. (For example, there may be a typographical error in recording the amount of charges.) Where the amount charged appears for any reason to be in error, discrepancies will be resolved prior to the payment of such claims. Fiscal Administrators should communicate with their State Medicare Committee or with the Office for Dependents' Medical Care, as appropriate, in unresolved or disputed cases or on matters not covered by this letter.

Claims received on or after July 1, 1958, for drug items furnished prior thereto may be paid in accordance with the policy in effect on that date.

The policy authorizing the furnishing of drugs to hospital inpatients remains unchanged.

The policy to the effect that an additional amount is not payable to a physician or surgeon who furnishes his own anesthetic equipment or materials will continue in effect.

Medicare patients may continue to obtain medication from pharmacies of uniformed services medical facilities upon prescription of a civilian physician if the items prescribed are available there or they may obtain such medication from civilian pharmacies at their own expense.

First Year of Medicare

Submitted to Congress recently was detailed report on first year of operation of Medicare, through December 31, 1957. Following are some of the highlights from the report:

Strong case is made for allowing dependents to elect civilian or military health and hospital services. To restrict freedom of choice (as House Appropriations Committee wishes to do) would impair servicemen's morale, promote deception by dependents preferring civilian care, increase administrative costs, alienate civilian physicians and be accompanied by other disadvantages, according to the report.

Indemnity Discussed

The document acknowledges that "distant rumblings for an indemnity plan have become more thunderous in some areas." In reply, the report says the program **does** embrace a number of indemnity, co-insurance, deductible and other features common to group health insurance plans.

"Despite isolated reiterations for straight indemnity by certain groups, notably leaders of organized medicine in widely separated areas, the proof of the satisfaction of the program lies with the individual physicians," it states. "During the first year of the program, there have been very few individual representations brought to the attention of the Office for Dependents Medical Care for an indemnity contract, or for any significant changes."

Statistics Listed

As of January 31, 1957, dependents living on American soil numbered an estimated 2,503,039. Air Force claimed 937,923; Army, 816,250; Navy, 562,466; Marine Corps, 139,600, and Public Health Service, Coast Guard and Coast & Geodetic Survey the remainder. Of those receiving Medicare

(Continued on Page 950)

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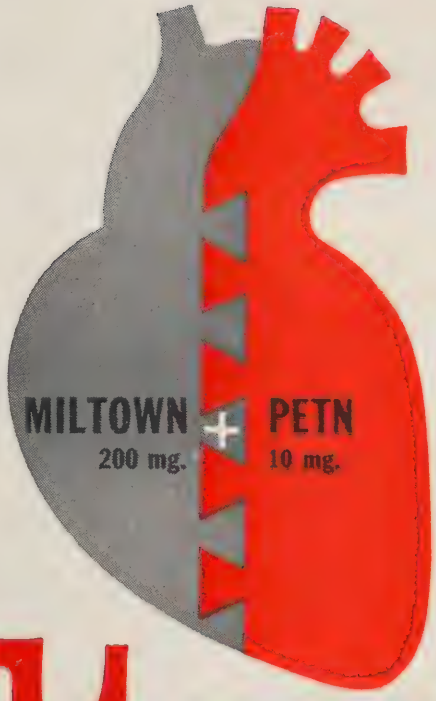
ANGINA ATTACKS

"In diagnosis and treatment [of cardiovascular diseases] ...the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, *as in Miltrate, "...appears to be more effective than* [PETN] *alone in the control of coronary insufficiency and angina pectoris."*[2]

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* 1:395, *March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* 8:504, *Dec. 1957.*

NEW
dovetailed therapy combines in ONE tablet



Miltrate*

proven safety for long-term use

prolonged relief from anxiety and tension with **MILTOWN®** — The *original* meprobamate, discovered and introduced by Wallace Laboratories

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Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.

Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.

Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 18A

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benefits, 97.9 per cent were under age 40 and 25 per cent were children under 14. Maternity cases accounted for 45 per cent of the total. Next in order was surgery (28 per cent).

Among maternity cases, 86.2 per cent culminated in normal deliveries; 2.3 per cent were complicated; 7.6 per cent were miscarriages and abortions; 3.9 per cent involved other complications of pregnancy. Military hospitals delivered 58,710 fewer babies in 1957 than in 1956.

* * *

How the Estate of a Deceased Doctor May Make Claim for Professional Services Under Medicare

The following information is from Major General Paul I. Robinson, MC, executive director, Office for Dependents' Medical Care (Medicare):

Claims for Services Rendered by Physicians or Dentists Now Deceased

1. The following requirements and procedures relating to the acceptable method by which claims for services rendered by physicians or dentists now deceased may be accepted and processed upon submission by personal representatives, executors, etc, are furnished for the information and guidance of all concerned.

2. a. In such cases, the DA Form 1863 should be executed as in other routine cases, with one exception. The certification set forth below should be accomplished by the deceased physician's or dentist's personal representative in lieu of the certification in Item 29 on the form and should be attached to the claim form:

Certification as to Services Rendered by Physician or Dentist Now Deceased

I certify that the attached statement is true and correct and that payment due from the Government under P. L. 569 has not been received; that said statement is for services which were rendered by Dr. ..... as the attending physician (dentist), or, as authorized by the attending physician (dentist); that he was not an intern, a resident, or otherwise in a training status at the time he rendered the care; that, except for the amount shown in Item 26, I will accept as full payment for services rendered by him and covered by P.L. 569 the amount of his usual fee shown in Item 24, or the amount finally approved by the Government, whichever is less. Services included in these charges in Item 24 which were of unusual degree involving excessive effort are explained by the attached Special Report. My acceptance of any amount from the Government for care included in this statement and authorized under P.L 569 will preclude me from accepting any amount therefor from the patient or other source in excess of that shown in Item 24.

b. In addition, evidence should be submitted to show the signatory's status as the personal representative of the physician's or dentist's estate —e. g., letters of administration, copy of court order appointing the person as executor, or other documentary evidence of the fact that the person is the personal representative of the deceased's estate.

c. Evidence should also be submitted sufficient to corroborate the fact that the services described on the DA Form 1863 were actually performed. The physician or dentist could have stated from personal knowledge that he performed the services; the personal representative may not have knowledge of the fact. The corroboration should be by someone having actual knowledge that the services were performed by the named physician or dentist—e. g., a hospital administrator or other hospital personnel, a partner of the physician or dentist, an office assistant to the physician or dentist, or the patient involved.

Ohio Girls Place 11th, 13th in AAPS Essay Competition

Miss Jane Litzinger, Somerset, Ohio, won 11th place and Miss Janet Holshoy, Massillon, Ohio, won 13th place in the recently completed Association of American Physicians and Surgeons national essay contest. Both received $75 awards for essays on "The Advantages of the American Free Enterprise System."

Miss Litzinger previously had placed third in the AAPS Ohio competition, while Miss Holshoy's essay was submitted directly to the national contest. Richard M. Dyer, Hiram, won first place in the Ohio contest, using the same topic. Contestants had their choice of that topic or "The Advantages of Private Medical Care."

Second place in Ohio contest was taken by Shirley Ann Wyse, Archbold. Honorable mention was given to Judy Strand, Mantua; Richard Curtis, Dover; and Cathy Ryan, Somerset.

Crippled Children Study Slated

Western Reserve University School of Medicine received a grant of $8,855 for a research project entitled, "Studies in the Immunological Factors in Homogenous Bone Transplantation." It is one of several projects sponsored by the National Society for Crippled Children and Adults promoting research in bone formation and malformation. Dr. Charles H. Herndon will direct the study at Western Reserve.

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Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal... high blood cholesterol levels are lowered, normal levels maintained.

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Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

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Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

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Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

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Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

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MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

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Sitosterols	130 mg.
Natural Tocopherols	15 mg.

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.

In Memoriam . . .

Clyde L. Cummer, M. D., Cleveland, outstanding physician and Past-President of the Ohio State Medical Association, died on June 7 at the age of 76. Dr. Cummer served the State Association over a period of many years. He was first elected Councilor of the Fifth District in 1927; was named President-Elect in 1932 and served as President in 1933-1934.



C. L. Cummer, M. D.

Dr. Cummer was a graduate of Western Reserve University School of Medicine, Class of 1907. He was a member of the Ohio State Medical Association, the American Medical Association, the American Dermatological Association and American Academy of Dermatology and Syphilology; diplomate of the American Board of Dermatology and Syphilology.

From 1909 to 1946 Dr. Cummer was on the teaching staff of Western Reserve University School of Medicine, for many years as assistant clinical professor of dermatology and syphilology. He was president of the Academy of Medicine of Cleveland in 1923 and served the Academy in many other ways. He was also an early member of the Cleveland Medical Library Association and was secretary of the committee which erected its building in 1926. He was chairman of its trustees from 1927 to 1937 and was its president in 1941.

During World Wars I and II he was on the advisory medical boards for Selective Service and during the Korean Conflict was a member of the board of medical appeals for the northern district of Ohio. Other organizations with which he was affiliated included several professional fraternities, the Pasteur Club of Cleveland, the Cleveland Dermatology Society, the Sons of the American Revolution, the Union, University, Hermit and Rowfant Clubs and the Ohio Historical Society. He was author of more than 50 professional articles. Surviving are his widow, a son and a daughter.

Robert V. Anderson, M. D., Springfield; Indiana University School of Medicine, 1926; aged 56; died May 18; former member of the Ohio State Medical Association and the American Medical Association. Dr. Anderson began his practice in North Lewisburg where he remained until he moved to Springfield in 1941. He was in private practice there until five years ago when he became industrial medical officer at Wright-Patterson Air Force Base. He was a member of the Presbyterian Church. Surviving are his widow, a son, three daughters, his mother and a brother.

Lawrence N. Atlas, M. D., Laguna Beach, California; Western Reserve University School of Medicine, 1930; aged 51; died May 19; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Atlas practiced for about 20 years in Cleveland and for a number of years was chief clinical instructor in surgery at Western Reserve. He moved to California about six years ago. Surviving are his widow, a son, a daughter and a sister.

John Edwin Brown, Jr., M. D., Columbus; Harvard Medical School, 1929; aged 55; died June 3; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Dr. Brown had been a practicing physician in Columbus since the completion of his medical training. A member of Columbus Academy of Medicine since 1934, he was serving at the time of death as chairman of the Academy trustees and was a member of the Academy council. He was associate professor of pediatrics at Ohio State University and his career included service in the Army Medical Corps from 1941 to 1945. He was a member of the Episcopal Church, several professional fraternities, the Rocky Fork Country Club, Medical Forum and Medical Review Club. Surviving are his widow, a daughter, two sons and his father, Dr. John E. Brown, Sr., retired physician.

Albert I. Civins, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1901; aged 81; died April 16; former member of the Ohio State Medical Association; recipient of the OSMA 50-Year Award. Dr. Civins had been a practicing physician in the Cleveland area for 55 years. He was a member of the Temple and B'nai B'rith. Surviving are his widow and a daughter.

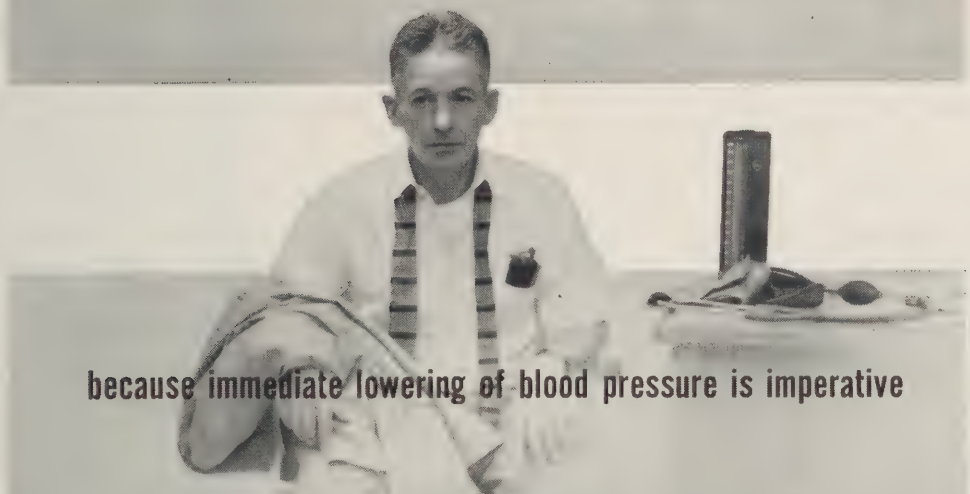
Pasquale G. Damiani, M. D., Peru, Indiana; Hahnemann Medical College and Hospital of Philadelphia, 1925; aged 58; died May 21. Dr. Damiani practiced for a number of years in Cleveland before he moved to Indiana about five years ago. His widow and a daughter survive.

Jerome S. Frankel, M. D., Cleveland; Ohio State University College of Medicine, 1941; aged

diagnosis: **hypertension, moderate to severe**

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(Rauwolfia Serpentina and Protoveratrines A & B Combined)



because immediate lowering of blood pressure is imperative

Rauwolfia Serpentina's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protoveratrine for effective therapy with a minimum of risk. Each of the agents appears to potentiate the other's hypotensive activity and produce beneficial vasodilitation, without ganglionic or adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which control blood distribution and which normally prevent postural hypotension.

Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

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PHARMACEUTICALS

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45; died June 1; member of the Ohio State Medical Association, the American Medical Association, the American College of Allergists; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Holder of both an M. D. and Ph. D. degrees, Dr. Frankel was director of education for Mt. Sinai Hospital and head of the Personnel Health Clinic. He was a founding member of the American Board of Clinical Chemistry; member of the American Association for the Advancement of Science, the Cleveland Diabetes Society, the American College of Allergy and the American College of Cardiology. Surviving are his widow, two sons, a daughter, his parents, two brothers and a sister.

Mose S. Griffith, M. D., Galesburg, Ill.; Miami Medical College, Cincinnati, 1907; aged 75; died May 4; former member of the Ohio State Medical Association. Dr. Griffith practiced in Batavia before World War I. He is survived by his widow and a sister.

Edwin A. Hannum, M. D., Birmingham, Michigan; University of Wooster, Medical Department, Cleveland, 1904; aged 85; died May 22; member of the Ohio State Medical Association through 1950. Dr. Hannum practiced medicine for 47 years in Cleveland before he retired and moved to Michigan. He is survived by his widow, and three sons.

Stephen S. Hudack, M. D., Enumclaw, Wash.; Western Reserve University School of Medicine, 1929; aged 57; died May 13; member of the Ohio State Medical Association through 1956. A physician in Cleveland for many years, Dr. Hudack retired last year as assistant clinical professor of surgery at Western Reserve and as head of the Department of Surgical Research and senior associate in the Department of Orthopedic Surgery at St. Luke's Hospital. He was former associate professor of orthopedic surgery at Columbia University and in World War II served as Navy lieutenant commander. He was a member of the American Association for the Surgery of Trauma; Fellow of the American College of Surgeons and member of the American Society for Experimental Pathology. Surviving are his widow, three brothers and two sisters.

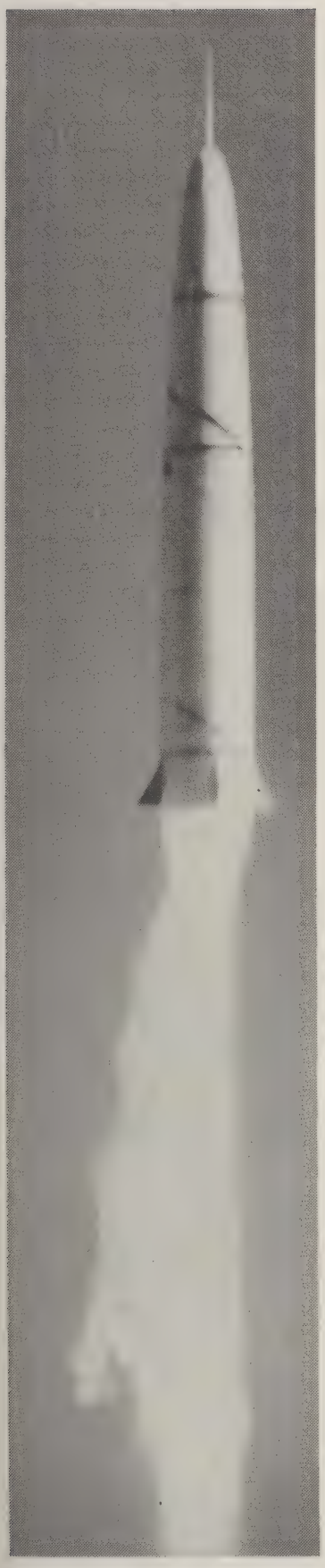
Ruth A. Koons Pereny, M. D., Columbus and Westerville; Ohio State University College of Medicine, 1930; aged 52; died June 9; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. Dr. Koons practiced for many years in Columbus under her professional name. She was assistant professor of medicine (cardiology) at Ohio State University College of Medicine. Surviving are her husband, Andrew Pereny, and a sister.

Loyal E. Leavenworth, M. D., Canton; Western Reserve University School of Medicine, 1914; aged 69; died May 20; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Leavenworth's entire professional career was served in Canton, with time out for service with the Navy Medical Corps during World War I. He was an active participant in the work of the Stark County Medical Society; was a past-president and former secretary of that organization and worked as member or chairman of numerous local committees; he also was a former delegate of the Society to the OSMA. He was equally active in many local civic affairs; was one of the earliest promoters of the Boy Scout movement; was active in the Canton Art Institute; he was a vestryman in the Episcopal Church; member of the Canton Club, the Chamber of Commerce, the Brookside Country Club and the YMCA. Surviving are his widow and two sons, one of whom is Dr. David Leavenworth, also of Canton.

Arthur B. McConagha, M. D., Lafayette, California; Ohio State University College of Medicine, 1909; aged 81; died May 15; member of the Ohio State Medical Association and the American Medical Association. Dr. McConagha practiced for many years in Columbus before his retirement in 1954. He formerly practiced in Ashley and Worthington. Affiliations included memberships in the Presbyterian Church and several Masonic bodies. His widow, a son, a brother and two sisters survive.

Francis E. Merritt, M. D., Barberton; Ohio State University College of Medicine, 1934; aged 48; died May 21; former member of the Ohio State Medical Association. Dr. Merritt had only recently opened an office in Barberton. He previously practiced in Akron and Amherst. Surviving are his widow, two daughters and a son.

William Mithoefer, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1897; aged 87; died May 26; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Otolaryngology, American Laryngology, Rhinology and Otology Society and the American Otological Society; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology. A native of Cincinnati, Dr. Mithoefer served all of his professional career



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there with time out for study in New York and abroad. He was active in the affairs of the Academy of Medicine of Cincinnati and was a past-president of the society. He also was a member of the Masonic Lodge. Surviving are his widow, three sons, three daughters and a sister.

Carl Clyde Nohe, M. D., Akron; University of Maryland Medical School, 1917; aged 65; died May 17; member of the Ohio State Medical Association and the American Medical Association; delegate of the Summit County Medical Society to the OSMA from 1952 to 1958; member of the OSMA Committee on Chronic Illness; editor of the Summit County Medical Society Bulletin for a number of years. Dr. Nohe began his practice in Akron after serving in the Army Medical Corps during World War I. His practice was supplemented by years of devotion to professional organization work. Survivors include his widow, three brothers and two sisters.

Clovis H. Phillips, M. D., Cleveland; University of Cincinnati College of Medicine, 1928; aged 54; died May 29; member of the Ohio State Medical Association through 1957; former member of the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. Dr. Phillips practiced his specialty for many years in Cleveland and was assistant clinical professor of obstetrics and gynecology at Western Reserve. He is survived by his widow and two sons.

James Earl Quigley, M. D., Edinburg; University of Maryland School of Medicine, 1911; aged 74; died May 13. Dr. Quigley was living in retirement in Edinburg after practicing for years in Butler, Pa. A brother with whom he resided and two sisters survive.

Philip W. Rieg, M. D., Lake Worth, Florida; Toledo Medical College, 1913; aged 71; died May 31; former member of the Ohio State Medical Association and the American Medical Association. Dr. Rieg practiced for many years in Toledo before his retirement about 10 years ago. His widow and a son survive.

Charles A. Simpson, M. D., Cleveland; Maharry Medical School, 1927; aged 62; died June 4. Dr. Simpson practiced for many years in Cleveland. He is survived by his widow and a son.

Emmet L. Thomas, M. D., Cleveland; Eclectic Medical College, 1918; aged 70; died May 16. Dr. Thomas practiced medicine for about 40 years in Cleveland. He was a member of the Masonic Lodge, the Compass Club and Sigma Pi. Surviving are his widow, a daughter and two brothers.

Fred R. Thompson, M. D., Massillon; University of Illinois College of Medicine, 1920; aged 65; died May 15. Dr. Thompson was assistant superintendent of the Massillon State Hospital, a post which he held since 1949. During World War II, Dr. Thompson served in the Navy Medical Corps, and before the war conducted a private practice in Columbus. Affiliations included memberships in the Methodist Church and the Lions Club.

David A. Tucker, Jr., M. D., Cincinnati; University of Cincinnati College of Medicine, 1916; aged 67; died June 3; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. Tucker began practice in Cincinnati after completing World War I service in France. He retired more than a year ago because of illness. For 40 years Dr. Tucker was on the faculty of the University of Cincinnati College of Medicine as professor of the history of medicine and assistant to the dean. His library on medical history will be given to the University. Over a long period of time Dr. Tucker contributed many articles to the Historian's Notebook section of *The Journal*. A past-president of the Academy of Medicine of Cincinnati, he was active in many affairs of the society. Other affiliations included memberships in Sigma Xi, Alpha Omega Alpha, the University Club and Cincinnati Country Club. Survivors include his widow and two sons.

Sigmund Wolf, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1909; aged 73; died May 14; former member of the Ohio State Medical Association. A native of Cincinnati, Dr. Wolf served all of his professional career there. He is survived by a sister and a brother.

New Movie Is Available on Social Security

The Chamber of Commerce of the United States has announced availability of a new 26-minute movie entitled "A Matter of Choice—What Everyone Should Know About Social Security."

This free 16-mm sound film points up the fact that American leaders and adults in all walks of life, as well as high school students, hold beliefs about Social Security which are founded more on fancy than on facts. "A Matter of Choice" clarifies some of the fundamentals of social security and of individual freedom of choice.

Requests for bookings should be sent direct to: Modern Talking Picture Service, 3 East 54th Street, New York 22, N. Y.

Georgia Dispute Settled . . .

Agreement Is Reached by Physicians in Private Practice, Medical School And Talmadge Memorial Hospital on Admissions, Disposition of Fees, etc.

AN intra-professional dispute which has been taking place in Georgia for several years, revolving around the administrative and operation policies of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital, apparently has been settled.

The House of Delegates of the Georgia Medical Association, meeting recently, adopted a statement of agreement, culminating five years of negotiations between representatives of that association, the Richmond County Medical Society, the medical school and Talmadge Hospital.

Following is the text of the policy statement as adopted by the Georgia House of Delegates and as published in *The Journal of the Georgia Medical Association:*

Liaison Committee

It was agreed that a liaison committee would be established to be constituted as folows. The district medical societies shall propose two names each and the Medical College of Georgia is to choose one name of the two. One member from each of the ten districts will provide ten members of the Liaison Committee. In addition, the Liaison Committee shall include an Executive Committee of two members of the Richmond County Medical Society to be chosen by RCMS, two members from the Medical College of Georgia to be chosen by the Medical College, and one member of the Medical Association of Georgia who resides outside of Richmond County, to be chosen by the Council of the Medical Association of Georgia. The full fifteen-man Committee shall meet once every six months. The Executive Committee, the Chairman of which shall be the MAG representative, shall meet as often as necessary and shall have power to deal with all matters subject to report to the full Liaison Committee.

Admissions

It is not and shall not become the policy of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital to enter into the competitive practice of medicine. Admission of patients of unusual teaching interest shall be favored. It is realized, however, that emergencies and unusual circumstances will arise in which patients who are not indigent will require the services of these institutions. No other pay (private) patients shall be admitted. This policy shall apply to both in and out patients.

The term "unusual circumstances" shall be understood to apply to those patients whose problems in the opinion of their referring doctor can be especially appropriately cared for at the Eugene Talmadge Memorial Hospital. Any question or controversy arising will be referred to the Liaison Committee in writing for the Committee's consideration.

No patient may be accepted by the institution except by proper referral of his *regular physician.*

Pay (private) patients admitted under the category of emergencies without referral by a doctor should be discharged or transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

Disposition of Professional Fees

Faculty members providing professional services to patients of the Hospital shall determine the charges for such services. The fees paid to the faculty members for such professional services may be paid into a special research fund. This special research fund shall not accrue to the general budget of the Board of Regents, Eugene Talmadge Memorial Hospital, or the Medical College of Georgia. Such special fund shall be used exclusively to defray the cost of medical research projects.

The faculty of the Medical College of Georgia shall determine the character and extent of such medical research projects to be supported by these funds. There shall be no contractual obligation between the Medical College of Georgia and its faculty members to pay such professional fees into the special Research Fund.

Public Relations

Publicity emanating from the Medical College of Georgia and the Eugene Talmadge Memorial Hospital shall be in good taste and consistent with the standards of the American Medical Association and the standards set by the Liaison Committee.

Vincent—Now in his 62nd year of medical practice, Dr. Harry W. Hill was the subject of an article in the magazine section of *The Dayton Daily News'* Sunday edition, recently. He holds an OSMA 50-year pin and graduated from Starling Medical College in 1894.

Short Course in Heart Disease Offered At University of Cincinnati

A postgraduate course entitled "Heart Disease —Current Concepts in Diagnosis and Treatment," will be presented by the University of Cincinnati, September 3-6.

The course will be under direction of Dr. Johnson McGuire, professor of medicine and director of the Cardiac Laboratory, University of Cincinnati, and will provide a review of recent advances in various aspects of heart disease. The faculty for the course has been selected from the Departments of Medicine, Radiology and Surgery of the College of Medicine.

The program will consist of lectures and panel discussions. Informal question and answer sessions have been planned in conjunction with the lectures and patient presentations.

Advance registration is requested. Tuition fee is $75. The course will be limited to the first 50 applicants. Applications should be sent to: Johnson McGuire, M. D., Cardiac Laboratory, B-4, Cincinnati General Hospital, Cincinnati 29.

The program is as follows:

Wednesday, September 3

9:00 **Physical Examination of the Cardiac Patient,** Noble O. Fowler, M. D.
10:00 **Heart Sounds and Murmurs,** Ralph Shabetai, M. D.
10:30 **Acute Rheumatic Fever,** Samuel Kaplan, M. D.
11:00 **Management of Cardiac Arrhythmias,** Harold Kotte, M. D.
2:00 **Panel on Cardiac Arrhythmias,** Drs. Johnson McGuire, Harold Kotte, Noble Fowler, Robert Helm.
3:00 **Bacterial Endocarditis,** Morton Hamburger, M. D.
3:30 **Hypertension in the Pulmonary Circulation,** Noble O. Fowler, M. D.
4:00 **Cor Pulmonale,** Remo DiSalvo, M. D.
4:30 **Pulmonary Function Tests,** Ralph C. Scott, M. D.

Thursday, September 4

9:00 **Coronary Artery Disease,** Johnson McGuire, M. D.
10:00 **Diagnostic Procedures in Hypertension,** Albert Brust, M. D.
10:30 **Ocular Fundi in Hypertension and Systemic Diseases,** Albert Brust, M. D.
11:00 **Reversible Systemic Hypertension,** Remo DiSalvo, M. D.
2:00 **Panel on Hypertension,** Drs. Johnson McGuire, Albert Brust, Remo DiSalvo.
3:00 **Management of Congestive Heart Failure,** Robert A. Helm, M. D.
4:00 **Electrolyte Disturbances in Cardiac Patients,** Harvey Knowles, M. D.
4:30 **The Heart in Endocrine Disorders and Avitaminosis,** Richard Vilter, M. D.

Friday, September 5

9:00 **Common Forms of Congenital Heart Disease,** Samuel Kaplan, M. D.
10:00 **Diagnostic Procedures in Congenital Heart Disease,** Samuel Kaplan, M. D.
11:00 **Surgical Aspects of Congenital Heart Disease,** James Helmsworth, M. D.
2:00 **Panel on Congenital Heart Disease,** Drs. Samuel Kaplan, James Helmsworth, Noble Fowler, Bernard Schwartz, Ralph Shabetai.
3:00 **Surgical Aspects of Acquired Heart Disease,** Leonard Gottesman, M. D.
3:30 **Diseases of the Aorta,** Virgil Hauenstein, M. D.
4:00 **Peripheral Vascular Disease,** Arnold Iglauer, M. D.
4:30 **Surgical Treatment of Diseases of the Aorta and Peripheral Arteries,** Alfred Keirle, M. D.

Saturday, September 6

9:00 **Radiology as a Diagnostic Aid in CV Disease,** Benjamin Felson, M. D.
10:00 **The Electrocardiogram as an Aid in Diagnosis and Management of Heart Disease,** Robert A. Helm, M. D.
11:00 **The Ballistocardiogram,** John R. Braunstein, M. D.
11:30 **Pericarditis,** Johnson McGuire, M. D.

Do You Know? . . .

Dr. Fred W. Dixon, Cleveland, Past-President of the Ohio State Medical Association, has been elected president of the American Laryngological Association for 1958-1959.

* * *

In recognition of his distinguished service in the fields of prevention of blindness and preservation of sight, the honorary degree of Doctor of Science was conferred on Dr. Claude S. Perry, Columbus, by Ohio Wesleyan University at its 114th Commencement June 9 at Delaware.

* * *

Dr. Thomas E. Rardin, Columbus, is the new president-elect of the Medical Alumni Association, Ohio State University. He was named to that post at the recent fifth annual reunion of the association. Dr. Robert J. Murphy was re-elected secretary.

Buckeye News Notes . . .

Bellefontaine—The blood donor program and its role in the community was discussed by Dr. Charles Browning before the Parent-Teachers Association.

Bryan—The Mothers' Club heard Dr. John P. Kemph, Lima, speak on "Discipline and Your Child."

Cincinnati—Dr. Edward A. Gall, professor of pathology and chairman of that department at the University of Cincinnati College of Medicine, recently completed a three-week lecture-consultant tour in Peru at the invitation of several medical groups and schools there.

Defiance—A demonstration of therapeutical hypnotism was given for members of the Child Conservation League by Dr. Robert J. Blough, of Deshler.

Delaware—Dr. Robert A. Vogel, former health commissioner for Delaware, Union, Madison and Morrow Counties, June 1 assumed the $20,000 a year post as Montgomery County health commissioner.

Fremont—Slides taken during his recent trip to the Orient were shown by Dr. Frank L. Moore at a special meeting of Ottawa County registered nurses.

Galion—Dr. Mart L. Helfrich, city health commissioner, has been accorded the Community Hospital Board of Trustees Distinguished Service Award.

Lima—Dr. Charles L. Steere attended the 50th reunion of his Northwestern University School of Medicine Class of 1908 in Chicago last May.

Massillon—Dr. Jeannette C. Miller on May 20 marked the beginning of her 51st year of practicing medicine in this city. She graduated from the Cleveland College of Physicians and Surgeons (now WRU) in 1908.

Orrville—Dr. E. J. Feltes was guest speaker at the Wooster Lions Club meeting, his subject being medical hypnosis.

Perry—The Perry PTA Preschool unit heard an address on safety by Dr. Robert Irvin.

Port Clinton—For his work as medical officer at the Erie Ordnance Depot, Dr. Lester N. Bates, Fremont, has been given an award for superior professional service.



Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

BUTLER

On May 28, a joint meeting of the Butler County Medical Society and the Butler County Bar Association was held. Principal speakers were Dr. Samuel R. Gerber, coroner of Cuyahoga County, Cleveland, and Dr. Frank P. Cleveland, Cincinnati pathologist and assistant coroner of Hamilton County.

HAMILTON

Dr. Clyde S. Roof, Cincinnati, has been elected president-elect of the Cincinnati Academy of Medicine. He will take office in September of 1959. Dr. J. Robert Hudson, current president-elect, will take over as president this September, succeeding Dr. George X. Schwemlein, retiring president.

Other new officers include: Dr. Ralph S. Grace, secretary; Dr. John A. Fisher, treasurer; Dr. Herbert J. Brinker, three-year trustee; Dr. Elmer R. Maurer, three-year councilman-at-large.

Delegates elected for a three-year term are Drs. Lester J. Bossert, Joseph G. Crotty, William A. Moore, Charles A. Sebastian and Daniel V. Jones. Alternate delegates include Drs. Robert A. Bader, Chapin Hawley, Donald L. Jacobs, John H. Payne, Carl F. Schilling and Edward Woliver.—*Cincinnati Post.*

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

DARKE

Dr. J. A. Mendelson, superintendent of the Dayton State Receiving Hospital, was guest speaker at the May 20 meeting of the Darke County Medical Society in Greenville.

MONTGOMERY

Members of the Montgomery County Medical Society were guests at Wright-Patterson Air Force Base for the May 28 meeting. Speaker was Col. R. R. Hesberg, chief of the biophysics branch of the Aero Medical Laboratory.

At the election, Dr. E. Wallace Smith, was named president-elect for 1959. New officers assume their posts on January 1. Other officers elected are: Dr. H. A. Bremen, vice-president; Dr. N. F. Stambaugh, secretary; Dr. P. A. Eckert, treasurer; Dr. L. E. Rausch, trustee; Dr. J. G. Tye, delegate; Dr. J. W. Priest, alternate delegate. Current president is Dr. A. V. Black. He will be succeeded on the first of the year by Dr. A. J. Carlson.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Dr. Leonard L. Loushin, Department of Medicine, Cleveland Clinic, was speaker at the meeting of the Lima and Allen County Academy of Medicine on May 20 in the Shawnee Country Club, Lima. His topic was, "Signs that Aid in the Recognition of Functional Disease." Approximately 80 persons attended.

HARDIN

The regular meeting of the Hardin County Medical Society was held on May 13 at Memorial Hospital, Kenton. The speaker for the evening was Dr. Robert J. Izant, Jr., of Children's Hospital in Columbus. His topic was "The Acute Abdomen in Children."—William F. Blinkley, M. D., Secretary-Treasurer.

HANCOCK

Guest speaker at the May 20 meeting of the Hancock County Medical Society in Findlay was Dr. William G. Myers, research professor of medical biophysics at Ohio State University. He described progress that is being made in the use of radio-isotopes in the medical fields. The dinner meeting was held at the Elks Home.

LOGAN

Dr. F. R. Grogan of Urbana addressed the Logan County Medical Society in May on the topic, "Symptoms, Diagnosis and Treatment of Inhalant Allergy."

SENECA

The Seneca County Medical Society held a dinner meeting on May 20 at the Country Club, Fostoria. There were 18 doctors in attendance to hear the program given by Cleveland doctors on heart surgery and surgery of the large blood vessels.—*Fostoria Review Times.*

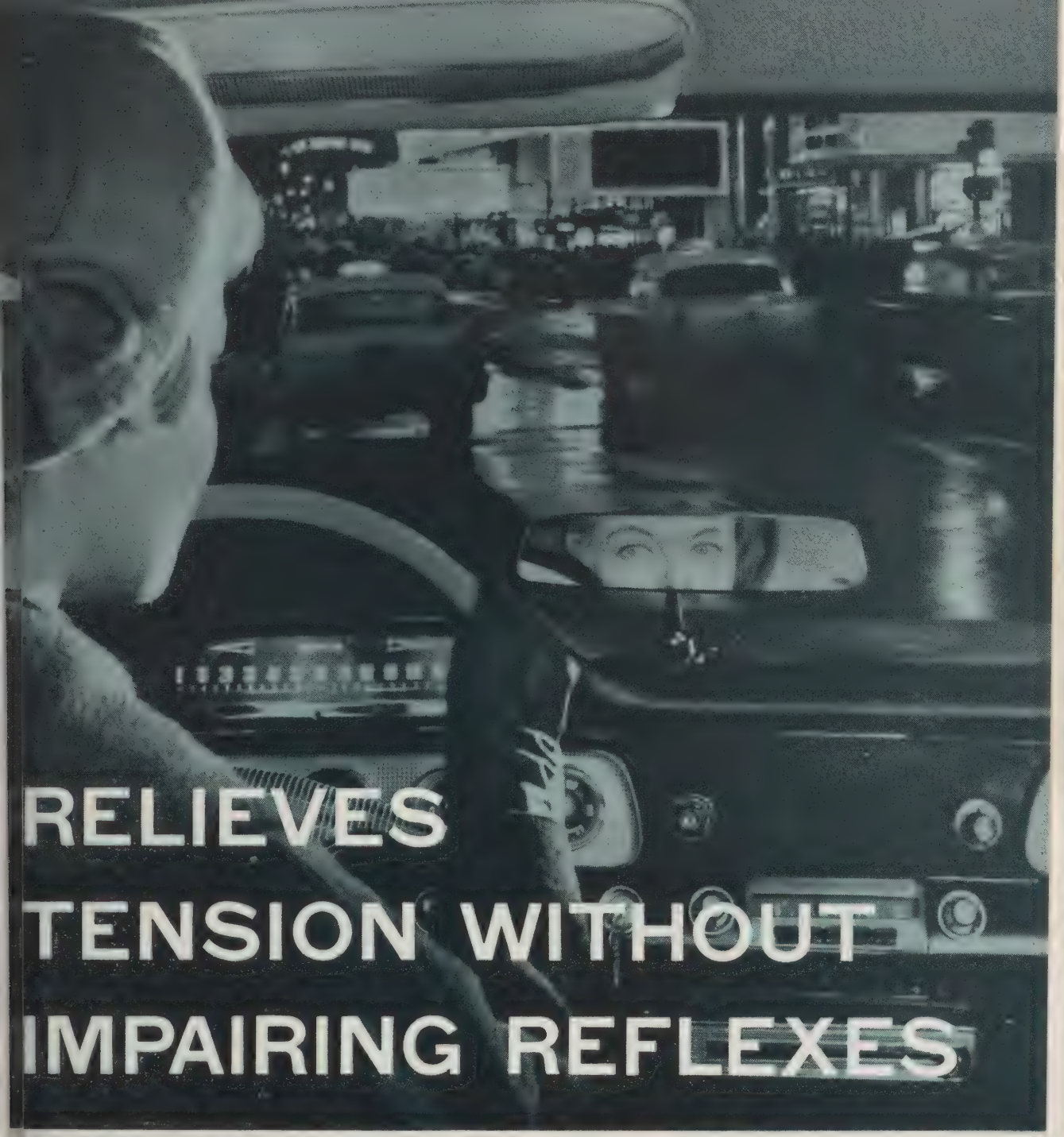
Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PUTNAM

April meeting of Putnam County Medical Society was held at Dumont Hotel, Ottawa, April 1.

Dr. Paul F. Orr, councilor for Fourth District, addressed the meeting on the subject "Social Security for Physicians." Dr. Orr's talk included a detailed analysis of advantages and disadvantages of participation in the Social Security program. He pointed out that the compulsory feature is contrary to the life-long traditions and thinking of



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*Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.

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most medical men; that it is not insurance; that it is a poor buy for most younger and middle-aged doctors. He cited the example of Sandusky County Society, whose members, after endorsing the plan 100 per cent, later reversed themselves and polled 100 per cent against it.

A discussion followed, after which Putnam Society turned down the proposal by a 90 per cent majority.—H. N. Trumbull, M. D., Corespondent.

SANDUSKY

A series of lectures for members of the Sandusky County Medical Society was given in connection with Medical Education Week in April. Lectures were given by members of a team from Wayne University College of Medicine, Detroit. The team consisted of Drs. Arnold Axelrod, Nathan S. Brooks and Harold L. Fachnie.

The afternoon program at the Fremont Federation Home was followed by dinner and an evening program.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

AUGLAIZE

Doctors of the Auglaize County Medical Society were entertained by the Woman's Auxiliary at a meeting on May 4 at the Country Club, Wapakoneta. Mrs. Fred Bettelini showed pictures and spoke of her visit to the Doctor Schweitzer Mission in French Equatorial Africa.

CUYAHOGA

The Academy of Medicine of Cleveland named Dr. Eugene A. Ferreri, Shaker Heights, as president-elect at the May election. He will take office as president in 1959.

Incoming president is Dr. Chester R. Jablonoski, who succeeds Dr. Thomas D. Kinney. Other officers are: Dr. Harry A. Haller, Jr., vice-president; Dr. B. B. Sankey, re-elected secretary-treasurer.

New trustees are Dr. Donald B. Cameron, Dr. E. Peter Coppedge, Jr., Dr. Robert M. Eiben, Dr. Pasquale A. Ferrara, Dr. John H. Nichols, Dr. John D. Osmond, Jr., Dr. Russell P. Rizzo and Dr. William Sinclair, Jr.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Dr. R. B. Trunbull, Jr., Department of Surgery, Cleveland Clinic, was speaker at the May 20 meeting of the Columbiana County Medical Society in Lisbon. His topic was "Staphylococcic Infections in Hospital Practice."

MAHONING

Mahoning County Medical Society members May 20 approved recommendations of their execu-

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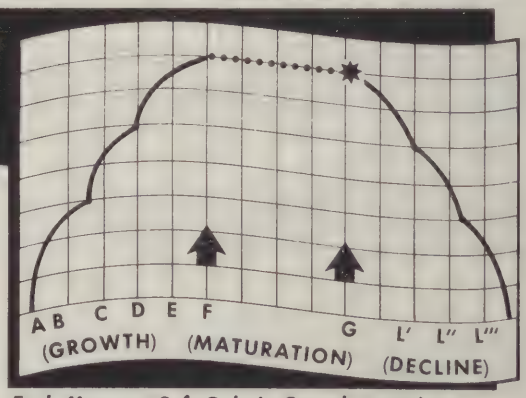
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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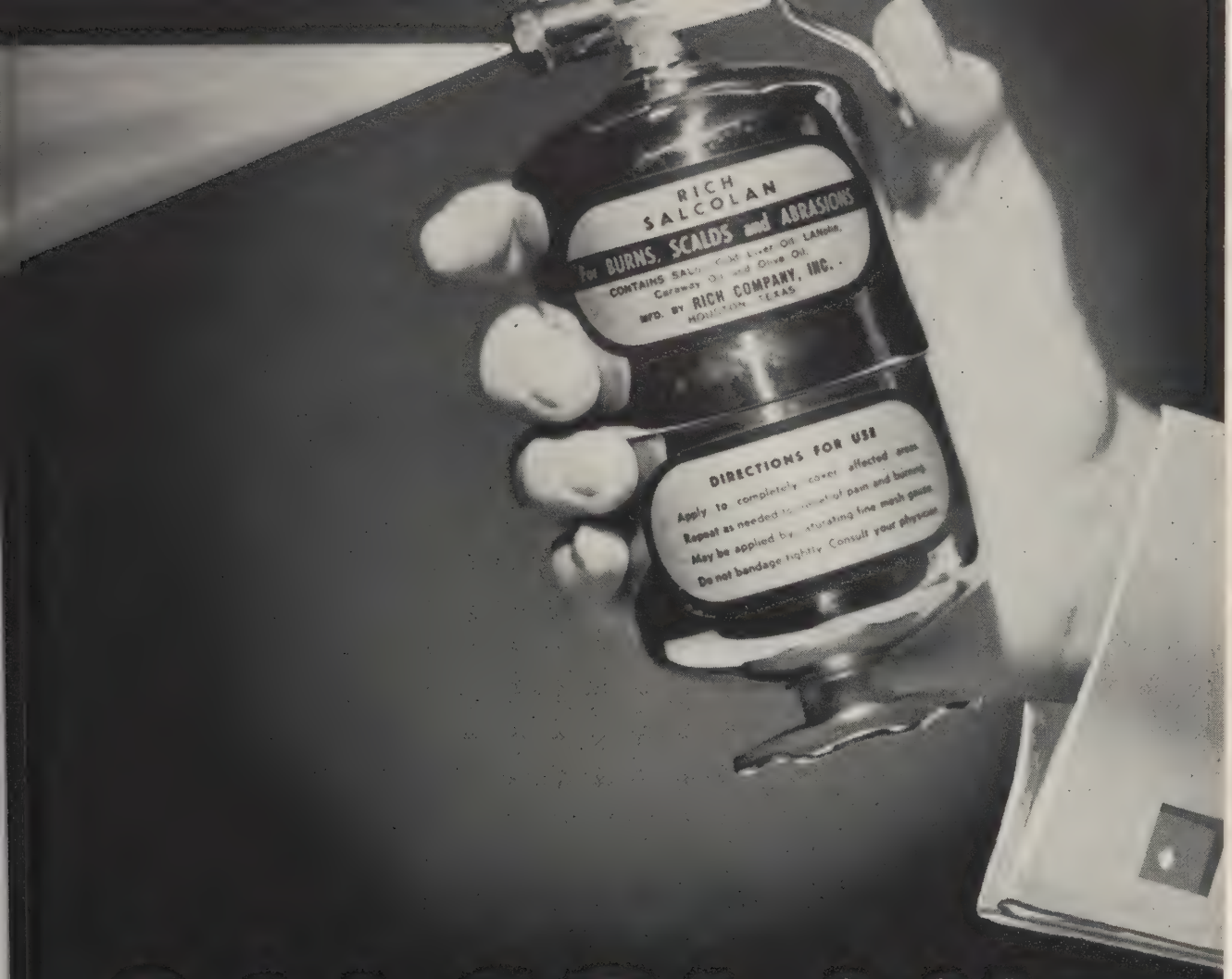


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tive and polio committees to give free third polio shots in their offices to children who already received the first two shots in mass immunization in the public and parochial schools.

The members also will continue to give polio shots in their offices to all persons 40 or under free of charge, where they are unable to pay. The action was taken at a special meeting at Tippecanoe Country Club.

Dr. Genevieve Delfs, chairman of the polio committee and Dr. A. A. Detesco, president of the society, say this is the recommendation of the American Academy of Pediatrics, which has made a thorough survey of the situation . . .

The medical society also hopes to have polio vaccination made a prerequisite for school entrance, Dr. Detesco said, and will act on this shortly. This would mean that a growing army of children would have these shots each year, along with smallpox, diphtheria and other vaccinations, now rated routine.

It was voted to boost membership dues from $30 to $75 annually, employ a qualified executive secretary and take some of the work load off the officers, busy physicians who do not have the time for it.

The meeting had the largest attendance in recent months and lasted 3½ hours as committee reports and other matters were discussed.—*Youngstown Vindicator.*

SUMMIT

"Anesthesia;New Hazards Added to Old," was the topic discussed at the June 3 meeting of the Summit County Medical Society. The speaker was Dr. Jay J. Jacoby, director of the Department of Anesthesiology, Ohio State University.

TRUMBULL

The Trumbull Country Club, Warren, was the scene of the final spring meeting of the Trumbull County Medical Society and Auxiliary on May 21. Headlining the evening's program of entertainment was John Frye and his hocus-pocus review.

The Society sponsored a blood donor day on June 6 in the Trumbull Memorial Hospital. It

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*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.

was recommended that each member give blood, or, if unable to do so, request that some member of the family, office staff or friend make the donation.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

ATHENS

The Athens County Medical Society met for the May program in the Mount St. Mary Hospital, Nelsonville, and heard a talk by Dr. Richard Welch on "Radiological Subjects."

A committee headed by Dr. Eleanora Schmidt and including Dr. A. A. Baldwin and Dr. William Allen, Jr., was appointed to administer a scholarship fund for prospective nurses from Athens County schools.

MUSKINGUM

The Muskingum County Pharmaceutical Association was host to members of the Muskingum County Medical Society on May 20.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society met on June 9 at the Portsmouth General Hospital. Two films were shown so that members could review them before they are shown before lay audiences. The films were "Time and Two Women," sponsored by the American Cancer Society; and "Hours to Live," sponsored by Hospital Care Association.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy of Medicine Bulletin periodically publishes an "honor roll" of physicians who have donated blood to the American Red Cross Blood program. A recent roll lists more than 90 physicians, 11 of whom are "Gallon Club members."

A joint meeting of the Columbus Academy of Medicine and the Central Ohio Academy of



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Robins

1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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Pharmacy was held on June 5. The following subjects were discussed by the speakers indicated:

"Steroids in Medicine," Byron Riegel, Ph. D., director of chemical research for the G. D. Searle Company, Chicago.

"Research Developments in the Field of Skeletal Muscle Relaxants," Dr. James M. Shaffer, director, Division of Clinical Investigation, McNeil Laboratories, Philadelphia.

"Current Function and Activities of the American Medical Association's Council on Drugs," Dr. H. D. Kautz, secretary, AMA Council on Drugs.

"Self-Medication and Our Professional Responsibilities," Linwood F. Tice, D. Sc., professor and associate dean of pharmacy, Philadelphia College of Pharmacy and Science.

The dinner meeting was held at the Neil House in Columbus.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since May 1st, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County
Julijonas Abraitis, Cleveland
Howard D. Arbuckle, Cleveland
Peter J. Brdar, Cleveland
Maria A. Crea, Cleveland
Alexander A. Klos, Cleveland
Mary Ellen McCarthy, Cleveland
Ivan H. Past, Cleveland
Victor Puskorius, Cleveland
Frederick A. Smith, Cleveland

Hamilton County
Celina D. Bobowski, Cincinnati
Erna L. Borousch, Cincinnati
Walter Schnur, Cincinnati

Lorain County
Robert S. Van Dervort, Elyria

Lucas County
Henrikas Solys, Toledo

Miami County
John D. Royer, Christiansburg

Ottawa County
Edward W. Kieffer, Elmore

Seneca County
Oswald G. Burkart, Tiffin

Stark County
Sylvester T. Centrone, Massillon
Yu-Ying Tsing Huang, Canton
Wayne L. McFadden, East Canton
Rudolf J. Nowara, Canton
Donald H. Volzer, Jr., Canton

Summit County
Richard H. Gollings, Barberton
E. Gates Morgan, Akron
Wilson D. Rees, Akron

Washington County
David D. Turner, Marietta

Greenfield—Dr. J. Martin Byers, Highland County coroner, was elected to the board of directors of the Ohio State Coroners Association at the group's annual meeting.

Van Wert—Dr. and Mrs. S. A. Edwards recently observed their 50th wedding anniversary. Dr. Edwards is a recipient of the OSMA 50-Year Pin.

Springfield—New president of the Ohio Valley Proctological Society is Dr. Ray M. Turner, of Springfield.





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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio

(See Page 857 for roster of officers.)

CUYAHOGA COUNTY

The Woman's auxiliary of Cuyahoga County met May 21 for its annual meeting at the Academy of Medicine office. A box luncheon was enjoyed.

Mrs. Roscoe J. Kennedy, the outgoing president turned the gavel over to Mrs. Fred R. Rittinger.

Dr. Samuel Gerber, county Coroner talked on "Crime Detection" and then took the group through the county morgue.

Mrs. William A. Nosik, skit chairman, reported on the play "Panacea for Petticoats" the auxiliary members gave at the Academy annual meeting May 16. Mrs. Myron M. Perlick wrote the play. Other chairmen were: Mrs. Rupert Turnbull, Mrs. William Kutler, Mrs. Eduard Eichner, Mrs. Ben Abrams, Mrs. Nathan Krupkin, and Mrs. Roscoe J. Kennedy.

ERIE COUNTY

Next year's officers for the Woman's Auxiliary to the Erie County Medical Society are Mrs. P. S. LaFollette, president; Mrs. C. F. Lavender, president-elect; Mrs. D. V. Auld, vice-president; Mrs. R. E. Taylor, secretary and Mrs. Malcolm Boylan, treasurer.

They were installed during the auxiliary's May meeting at the home of Mrs. H. E. Snedden.

Mrs. W. P. Skirball conducted the business session which concluded her year in the presidency.

Reports on the recent Ohio State Medical Auxiliary convention in Cincinnati were given by Mrs. LaFollette and Mrs. Lavender. Their good tidings included the news that together with other local auxiliaries, the Erie County Auxiliary received a certificate showing it is a component unit of the Woman's Auxiliary to the Ohio State Medical Association.

Harry Mansfield, executive secretary of the Sandusky YMCA was the speaker of the afternoon. He discussed the origin of the "Y" and explained the meaning of its emblem.

Tea was served at a table appointed with spring blossoms and pink candles. Mrs. LaFollette and Mrs. Lavender presided. Mrs. C. R. Swanbeck, Mrs. R. D. Fishell and Mrs. E. J. Baxter assisted Mrs. Sneddon on the hostess committee for the day.

FAIRFIELD COUNTY

The Woman's Auxiliary to the Fairfield County Medical Society was invited to the home of Mrs. F. W. James for its May meeting. Assisting Mrs. James were, Mrs. C. B. Snider, Mrs. James Beesley, Mrs. K. W. Taylor, Mrs. A. B. Van Gundy.

Lunch was served to 22 members and two guests, Mrs. Hector McKnow, president of the Woman's Auxiliary to the Licking County Medical Society and Mrs. J. R. Wells, Newark, director of the Eighth District of the Woman's Auxiliary to the Ohio State Medical Society.

Mrs. George LeSar presided for the business meeting. A report of the Ohio State Medical Auxiliary Convention was presented by Mrs. G. F. Jones.

The following officers for the Fairfield County Medical Auxiliary were installed by Mrs. Wells: President, Mrs. G. F. Jones; Vice President, Mrs. James Beesley; President-Elect, Mrs. C. F. Clark; Secretary, Mrs. W. D. Nusbaum; Treasurer, Mrs. C. H. Hamilton.

Mrs. LeSar presented Mrs. Jones with the gavel and the new president announced the appointments of committee chairmen.

In addition to the various other projects sponsored by the Medical Auxiliary, the group is currently concerned with providing recreational equipment for the student nurses of the Lancaster-Fairfield Hospital School of Nursing.

HAMILTON COUNTY

A buffet supper followed by informal and square dancing replaced the usual May meeting of the Woman's Auxiliary to the Hamilton County Medical Society. A country atmosphere accented with scarecrows prevailed at the Hartwell Country Club on the evening of May 20. Straw hats and sunbonnets were provided as table favors, and became the appropriate headdress for the party.

Mrs. Earl C. Van Horn was installed as president for 1958-59 in a brief business interlude. Others taking office were Mrs. Don Berning, president-elect; Mrs. William C. Ahlering, vice-president; Mrs. Edward O. Hoffman, recording secretary; Mrs. George Ballou, corresponding secretary; and Mrs. Charles Hoyt, treasurer.

Thirty-nine members were entertained at an informal gathering on May 7 at the home of Mrs. Van Horn. Officers and members of the executive board also attended the party, for which the new members planned the entertainment. It was the third and final orientation meeting of the year.

KNOX COUNTY

The Woman's Auxiliary to the Knox County Medical Society held its annual luncheon in the Alcove on May 28.

Following the lunch, Mrs. C. H. Bell of Mans-



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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field, the new state auxiliary president, was introduced. She addressed the group on the auxiliary work in National, State, and County levels. She stressed the importance of the work done by small groups.

The new officers installed were: President, Mrs. George Imhoff; president-elect, Mrs. A. S. Mack; vice president, Mrs. Charles Tramont; secretary-treasurer, Mrs. O. W. Rapp.

Mrs. James F. Lee, Mrs. Charles Tramont, and Mrs. Howard Dillon were hostesses.

MAHONING COUNTY

Funds were raised for two nursing scholarships, one for St. Elizabeth and one for Youngstown Hospital, and $350 was contributed to the American Medical Education Foundation, reports revealed at the annual meeting of the Woman's Auxiliary to the Mahoning County Medical Association on May 7 at Youngstown Country Club.

Mrs. Cary S. Peabody, president, presented the review of the past year's accomplishments. Mrs. Robert L. Tornello was chairman of the scholarship committee. The paid-up membership now totals 229. Mrs. Paul J. Mahar gave a report of the state convention held in Cincinnati, at which the local auxiliary received an award for selling the most subscriptions to *Today's Health,* the official magazine of the American Medical Society. Mrs. Lester Gregg was chairman for that project.

New officers, headed by Mrs. Earl H. Young as president, were installed by Mrs. Ivan C. Smith, a past president. Mrs. C. E. Prichette, vice president, Mrs. James A. Patrick, corresponding secretary, Mrs. E. M. Thomas treasurer, Mrs. Edward G. Rizk recording secretary, and Mrs. A. E. Rappoport president-elect. In appreciation of her service, Mrs. Peabody was presented a gavel, a gift from the auxiliary, by Mrs. Mahar.

Dinner appointments were beautiful. Mrs. Mahar offered the invocation, and Mrs. R. M. Morrison read the auxiliary pledge.

Featured on the program was the humorous skit, "Doctor, This Is Your Wife," a take-off on auxiliary committee work, directed by Mrs. Frank Inui, program chairman for the evening.

Mrs. Inui's co-chairmen were Mrs. B. I. Firestone and Mrs. Alfred Cukerbaum. Mrs. Fred Schlecht was social chairman, with Mrs. Stillson, Mrs. Ben Brown and Mrs. Harry Smith as her co-chairmen.

SCIOTO COUNTY

Spring flowers decorated the home of Mrs. H. M. Keil for the annual May breakfast of the Woman's Auxiliary of Scioto County Medical Society. Each member was presented with favors of miniature china roses.

Installation of officers by Mrs. Clyde M. Fitch, a past-president of the auxiliary, followed the breakfast.

The new officers are President, Mrs. Armin Melior, President-Elect, Mrs. A. L. Berndt, Vice-President, Mrs. William Singleton, Secretary, Mrs. L. B. Hatch, Treasurer, Mrs. G. E. Neff, Historian, Mrs. Milton Levine, and Mrs. George W. Martin, advisory board.

Mrs. Samuel L. Meltzer, past state vice-president and new state chairman of credits and awards, reported on amendments voted by the Woman's Auxiliary of the Ohio State Medical Association at the convention in Cincinnati.

Mrs. Hugenberg, the retiring president, also reported on the state convention.

SUMMIT COUNTY

The Woman's Auxiliary to the Summit County Medical Society met for a brunch on May 6 at the Akron City Club.

Members were pleased to have Mrs. V. R. Frederick, 1957-1958 President of the Woman's Auxiliary to the Ohio State Medical Association to install the following officers for 1958-1959: President, Mrs. Devitt L. Gordon; president-elect, Mrs. Robert J. Hemphill; vice-president, Mrs. Carl T. Korsmo; treasurer, Mrs. Robert S. McMillen; recording secretary, Mrs. A. H. Loomis; corresponding secretary, Mrs. B. F. Suffron.

Delegates to the State Convention were Mrs. Philip B. DeMaine, Mrs. Joseph J. Eckert, Mrs. H. E. Muller and alternate Mrs. Donald I. Minnig.

The program was a skit starring several members of the Auxiliary entitled "Doctor, This is Your Wife." Mrs. A. H. Kyriakides was chairman.

Ohio Physicians Participate in Obstetricians' Program

Several Ohioans participated in the recent sixth annual clinical meeting of the American College of Obstetricians and Gynecologists held in Los Angeles.

Dr. Richard D. Bryant, Cincinnati, was chairman of the Scientific Exhibit Committee.

Dr. John C. Ullery and Dr. John H. Holzaepfel, Ohio State University, received honorable mention for their exhibit, "Radioactive Isotopes in Gynecologic Malignancies."

Drs. Howard P. Taylor, William A. Hawk and John J. Cahill, Cleveland, received honorable mention for their exhibit, "Placenta Accreta, Increta and Percreta." This exhibit was displayed at the OSMA Annual Meeting in Cincinnati also.

Dr. Ullery is current secretary of the organization.

Voluntary Health Agencies . . .

The Columbus Academy of Medicine Completes Its Survey of Health Organizations; Recommends Combined Single Fund-Raising Campaign

A COMPLETE survey of the activities of 38 voluntary health agencies in Columbus and Franklin County has led the Columbus Academy of Medicine to recommend that all fund-raising health agencies combine into a single united fund campaign.

The survey began in 1957 with the appointment of a Fund-Raising Health Agencies Screening Committee, a sub-committee of the Academy's Medical Service Committee.

The committee's assignment was to conduct a fact-finding survey of the voluntary health agencies.

Asked 78 Questions

The committee devised a questionnaire for the survey. It consisted of 78 questions concerning organization and function. The 38 agencies then were personally surveyed by members of the committee. Findings of the committee included information that total funds administered by the 38 agencies amounted to $6,573,132, with $3,087,184 being expended for health and the remaining $3,485,948 for welfare activities of those health agencies.

The questionnaire covered the individual agency's affiliations with national, state or central Ohio agencies, including a list of counties where applicable, purpose and objectives.

Data Developed

It developed data on organization, method of elections, medical advisory board, paid personnel, volunteer groups and special committees. It also determined if the agency's local campaign was federated or separate. If the latter applied, the relationship to national campaigns was studied.

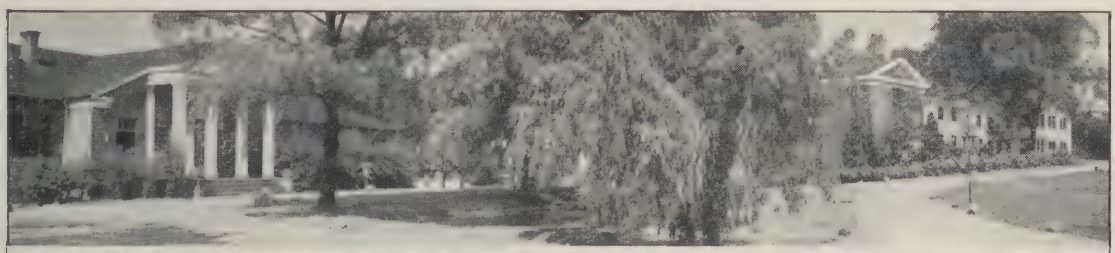
Financial information obtained included total budget, sources, allocations to local, state and national organizations and the use of those allocations, monies returned to Columbus as research grants, local salaries and other fixed costs.

Activities, education, care programs and services were covered in detail, along with anticipated budget and program increases.

The committee determined the need for each particular health agency in the community by studying the incidence of the disease and the local scope of the problem. These data included total cases listed by each agency in Franklin County, incidence in the general population, anticipated new cases per year, importance of the disease as a cause of death, and anticipated old cases requiring care per year.

Academy Report

In its report to the Academy, the committee stated, "The question was asked as to whether or not local services and facilities, other than those of the local chapter, could provide such services. The need for research was discussed and local expenditures for research during last fiscal year were listed, including the recipient, progress reports and publications. The need for free medication and treatment was estimated when possible. Finally, recommendations were made to be presented



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to the Academy members of the (United Appeals) Screening Committee."

Of the 38 agencies surveyed, 19 were United Appeals participants and 19 were not.

Advocates Screening Committee

As a result of the survey, the Columbus Academy proposed a central screening committee, consisting largely but not entirely of physicians, which would consider all disease and health needs of the community in setting campaign goals and allocating funds.

Other results of the committee's activities:

An offer to each agency to provide a list of physicians interested in specific disease entities and willing to serve on medical advisory councils.

An invitation to each agency to prepare a short summary of its organization, objectives, including services useful to physicians in their practice, for publication in the *Academy Bulletin.*

Continuation of the subcommittee as a permanent unit, with appointment on a three-year rotating basis.

Research Funds Available

Recommendation that interested physicians in Franklin County apply for research grants from national health agencies since "far more funds are leaving our community than returning to it."

Strong recommendation that considerable thought be given to the possibility of a unified voluntary health drive to obtain funds for all voluntary health agencies.

"Finally, the Committee is unanimously in favor of continuing growth and physician support of the voluntary health agencies, having been firmly convinced that contributions to these activities are far better than the dead hand of government taxation."

The report and recommendations drew the endorsement of the Columbus United Appeals board of trustees.

Interprofessional Committee Formed in Clark County

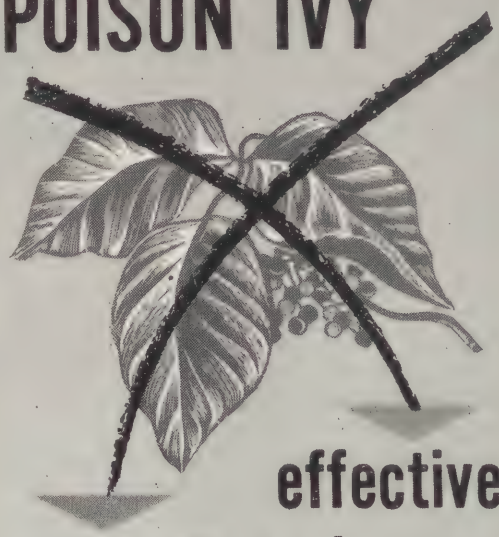
Clark County Medical Society has been instrumental in organization of an Interprofessional Medical Committee, which includes, in addition to the medical profession, representatives of nursing, pharmaceutical, dental and veterinary organizations.

The committee was formed to sponsor medical exhibits at the Clark County Fair, sponsor public health projects, prepare monthly news items for public interest, provide speakers for youth groups, have a standby disaster committee, correlate public information related to the different professional fields, bring together mutual problems, and to bring the professional groups closer together.

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Hospital Questions . . .

Queries Are Answered by Joint Commission on Accreditation in Regard To Various Matters and Policies Dealing With Hospital Administration

THIS is another article presenting questions which have been asked of the Joint Commission on Accreditation of Hospitals and the Commission's answers:

May a hospital staff grant privileges to a chiropodist? What is his status? What are his privileges?

A hospital staff may vote a chiropodist privileges in his specialty. Each hospital staff must evaluate the chiropodist who applies for hospital privileges and set up qualifications, rules and regulations. Granting privileges to a qualified chiropodist will not cause the hospital to be penalized by the Joint Commission.

Chiropodists must be under the jurisdiction of the department of surgery. A physician must be in attendance when the chiropodist is performing in the hospital on an inpatient. Where minor outpatient podiatry is performed, it will be done under the supervision of the surgical department though actual attendance is not required. The chiropodist is in the nature of a technician, functioning under the surveillance and supervision of a physician.

Limitations Noted

The chiropodist is not qualified to write the history or physical examination nor check the heart and lungs before an anesthetic. This applies also to prescribing drugs both pre-operatively and post-operatively in the hospital. These functions can only be performed by a physician on the staff or having privileges in the hospital in question. The podiatric patient must be admitted to the hospital under the physician's name. The chiropodist cannot and does not have the privilege of admitting a patient under his own name.

It is in no way obligatory that a chiropodist be given privileges. It is up to each individual hospital staff to evaluate the hospital's needs, the individual's qualifications and competence, and then vote on the matter with recommendations to its board of trustees. The board of trustees of any hospital, before giving approval to such election, should make sure that the hospital's by-laws, rules and regulations spell out all facts and privileges.

Is it necessary to have consultation on every "D and C"?

No. The standards state specifically that a consultation is necessary only when a pregnancy is definitely present or suspected. If pregnancy is suspected, a pregnancy test would be very wise as a precautionary measure.

No consultation is necessary if the physician has definitely seen products of conception passed (incomplete abortion). It likewise is unnecessary when there is no question of pregnancy, but the physician desires to do a diagnostic "D and C" to determine if some other pathology, such as possible endometriosis or cancer, is present.

Mass Casualties

We have been told by the Joint Commission on Accreditation of Hospitals that besides a fire plan and drills, we must have a plan and drills for the reception and handling of mass casualties and for the evacuation of patients. How do we do it? Is this the same as civil defense or disaster planning?

No, this is not civil defense, but a good plan for reception of mass casualties and evacuation of patients is a main facet of a civil defense hospital program and could easily be coordinated into and with it. The JCAH requirement is that you have a planned and rehearsed program to take care of a major catastrophy within your own hospital, or within your own community if it occurs.

Each hospital must have its own individual plans. Every effort should be made to coordinate the hospital's plan with those of other hospitals and other community agencies and organizations.

I. **Drills or rehearsals of these plans should be held at least twice a year.** Care should be exercised so that all shifts know the plans and take part in them.

II. **Every hospital must have a written plan.** It should embody the following basic components:

A. Evacuation.
   1. Internal (to other parts of the hospital).
   2. External (to homes, other hospitals or designated areas).

B. Reception and expansion.
   1. Internal (usage of hospital personnel and facilities).
   2. External (usage of above plus available outside facilities).

C. Continuation of services provide for alternative sources of vital utilities and supplies of

foodstuffs, fuel, medical-surgical and pharmaceutical items.

D. Coordination and integration.
   1. With plans of other hospitals.
   2. With plans of community agencies and organizations (police, fire department, health department, Red Cross and Civil Defense).

Categories I and II should be broken down into explanations of the functions and duties of personnel and of usage of facilities and equipment. General considerations for this programming are:

1. Authority.
   a) Lines of authority must be established.
   b) Organizational chart.
2. Personnel.
   a) Lists of key personnel—notification procedures.
   b) Duty assignments.
3. Communications.
   a) Notification.
   b) Duties.
   c) Usage of communications.
   d) Communication center.
4. Traffic control.
   a) Plans for both internal and external control.
   b) Traffic flow charts.
5. Utilities.
   a) Prior arrangements in case of loss.
   b) Alternate sources.
6. Records and identification.
7. Supplies and equipment.
   a) Usage of available equipment and supplies.
   b) Sources of supplies.
8. Public information center.

Every hospital department and service should know its duties and functions. These include: administration, medical staff, nursing staff, pharmacy, central supply, medical records, dietary, engineering and maintenance, personnel, supply, housekeeping, laundry, information and communication, and business and admitting.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 29 through October 5, 1958. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Hospital Agreement Violates Fee Splitting Principle Judicial Council Says

An opinion on fee splitting was rendered by the Judicial Council of the AMA to a member of the American College of Surgeons at the request of the Chairman of the Board of Regents of the ACS. It was in the form of a letter from the Executive Secretary of the Council, reading as follows:

"Dr. Ravdin, chairman of the Board of Regents of the American College of Surgeons, has referred certain correspondence of yours which refers to an agreement between physicians and a hospital . . . to the Association for consideration and reply.

"From this correspondence it appears that the hospital in question has proposed that collections from all outpatient x-rays are to be divided equally between the member of the medical staff who ordered the x-ray and the hospital; and that collections from all inpatient x-rays are to be retained by the hospital with the exception of radio-opaque studies of soft tissues which will be divided equally between the hospital and physician. This agreement recognizes that pathology and radiology are medical services and provides that itemized statements will show the name of the doctor rendering the service and the charges by the doctor and the hospital . . . In the absence of a competent radiologist in the area, each doctor interprets his own x-rays.

"The Judicial Council has stated that a physician himself should submit a bill for the professional service he renders to the patient. (It has not said that this bill may not be submitted by another for him on his behalf.) The Judicial Council has for many years expressed disfavor with the practice of sending a combined bill. Consequently the fact that the hospital sends an itemized bill showing the charge of both hospital and physician would seem to be contrary to interpretation of Chapter I, Section 6 of the *Principles of Medical Ethics* by the Judicial Council. (The reference is to the 1955 edition of the *Principles of Medical Ethics,* which were revised by action of the A. M. A. House of Delegates in June, 1957. However, the Judicial Council has stated that no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 version.) The contract offered by the hospital merely provides a procedure whereby the bill for two distinct services is sent patient.

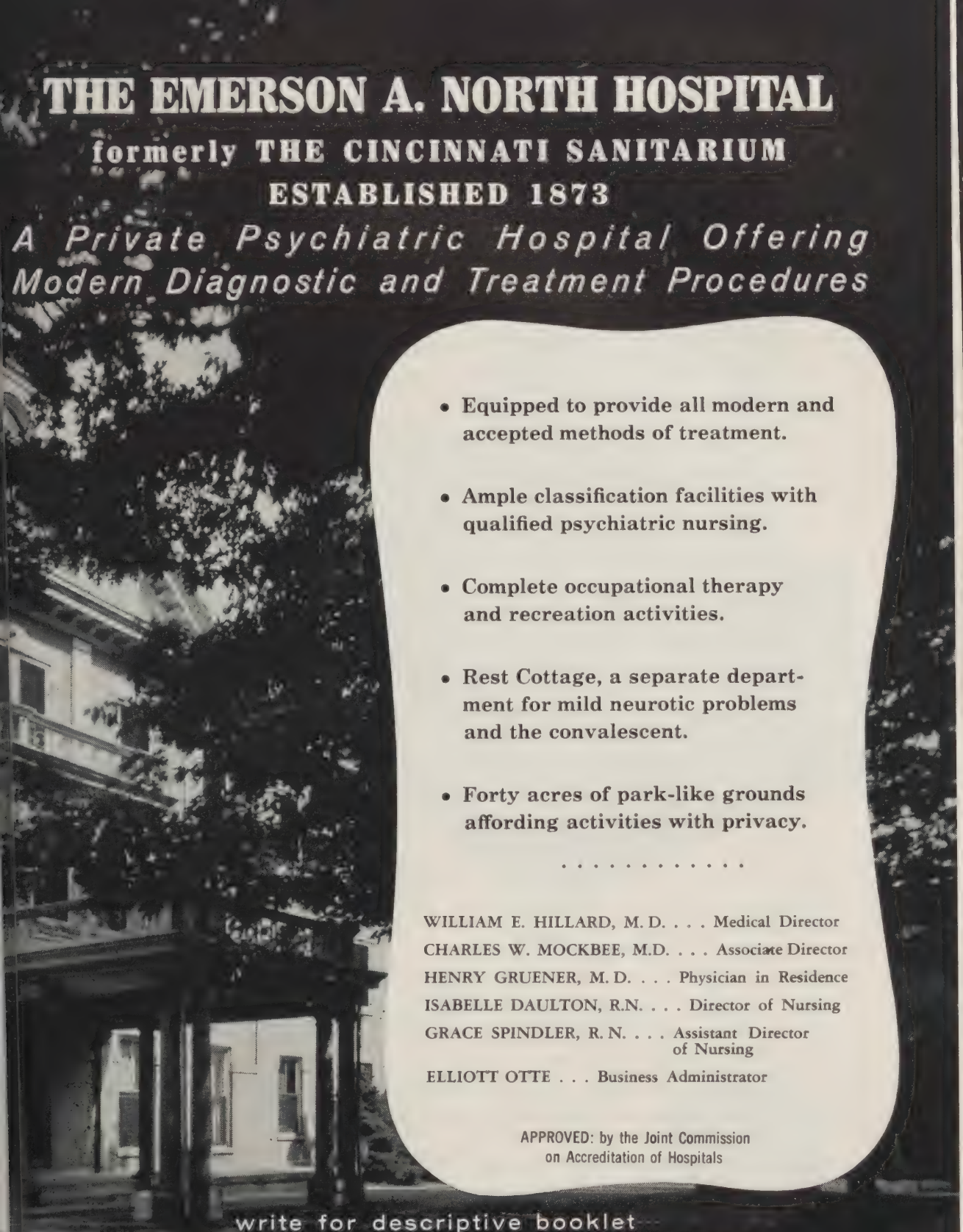
"The Association has never recognized that radiology or pathology is divisible into professional and nonprofessional aspects. Pathology and radiology

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are the practice of medicine. They are to be practiced only by those qualified and licensed to perform them. Fees for that professional service are to be set, billed and collected by the doctor who actually performed the service. No provision is made in the contract providing who shall set the fee for the 'service.' It merely provides how the fee is to be divided and may put the physician in the position of having to set his fee for a professional service according to the wishes or dictates of the governing board of the hospital.

"The Judicial Council in a special report to the House of Delegates in June 1954 reiterated its opinion that separate bills should be submitted by physicians for the services they rendered to their patients. It recognized that some insurance companies demand a single bill. Even though a single bill might be demanded, the Judicial Council insisted that physicians should, however, seek separate remuneration for their services. It is to be doubted that the Judicial Council would approve of a joint bill of a hospital and a doctor, any more than joint bills of doctors.

"In another opinion of the Judicial Council, having to do with groups and clinics, the Council pointed out that an arbitrary 50-50 division of an amount received for services performed by physicians associated with one another in practice is not justifiable under the *Principles of Medical Ethics*. If for bookkeeping purposes a division of income according to percentage is desirable and warranted, such ratio must be in proportion to the services contributed by each doctor.

"An analogy seemingly would apply here. The contract provides for a 50-50 distribution but does not establish that the professional service of the doctor is equal to 50 per cent of the bill submitted. In other words the arrangement is arbitrary and the 50 per cent allotted to the doctor has no relation to the value of the professional service performed by the doctor."

Policy on Industrial Medical Services Adopted in Dayton

The Montgomery County Medical Society has adopted a policy on industrial medical services. The policy which is now in effect is as follows:

1. The policy set down in a pamphlet, "Guiding Principles of Occupational Medicine," as published by the Council on Industrial Health of the A. M. A. in 1954 and a similar brochure, "The Scope of Industrial Medicine," published in 1957 is accepted.

2. "An industrial physician shall not, while caring for an industrial injury or disease urge a patient to have an unrelated concomitant and coincidental disease treated by himself at the worker's expense."

3. "When a case is diagnosed as non-occupational, the patient is referred to the physician of his choice."

4. "The treatment of injuries or diseases not occupationally induced is the function of private medical practice."

5. Radiological procedures in nonindustrial cases should cease entirely, except for pre-hiring chest films or when occupational disease is suspected.

6. Laboratory studies performed on employees, should be limited to those cases directly concerned with an occupational disease or injury, or when there is a question of continuing employment.

7. Private physicians shall refrain from requesting medical departments of industry to perform laboratory and x-ray studies on non-occupational diseases or injuries. If the employee himself requests the medical departments for laboratory or x-ray films, the industrial physician should refer the employee to the private physician of his choice.

8. Failure to conform with these policies will be considered a violation of medical ethics.

ACR Policy on Retention Of X-Ray Films

The American College of Radiology has adopted the following suggested policy regarding the retention of x-ray films:

Properly made medical roentgenograms of human beings are objective records of certain aspects of the status of the person, or persons, so examined. As such, they may constitute valuable records.

Valuable records should be stored as long as is locally practicable. This may be done by storing the original roentgenograms, or storing standard size or reduced size copies of same. Selected or key roentgenograms may be selected for copying.

When space, or other requirements, demand limitation of storage, it is recommended that in the average office or department roentgenograms be maintained for at least five years. It is desirable that apparently negative chest films of adults be maintained, if possible, for 10 years. In many offices and departments roentgenograms of teaching value, or of an unusual nature, are filed *sine die*. This is to be encouraged.

Before discarding roentgenograms, it is recommended that when practical the referring physician or, at his discretion, the patient be given the opportunity of obtaining them for filing in a safe place.



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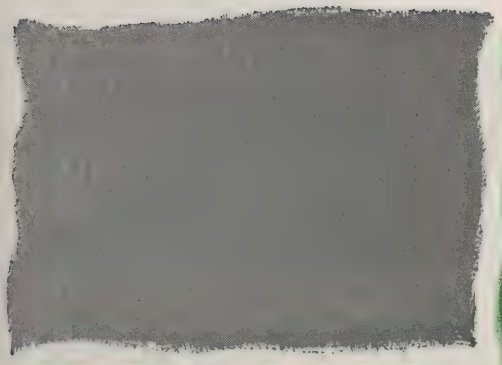
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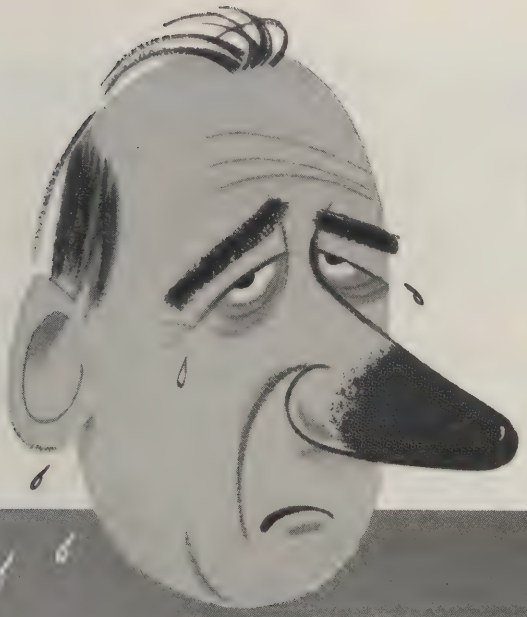
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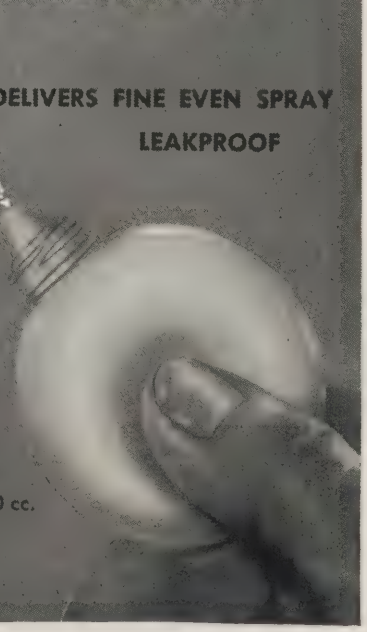
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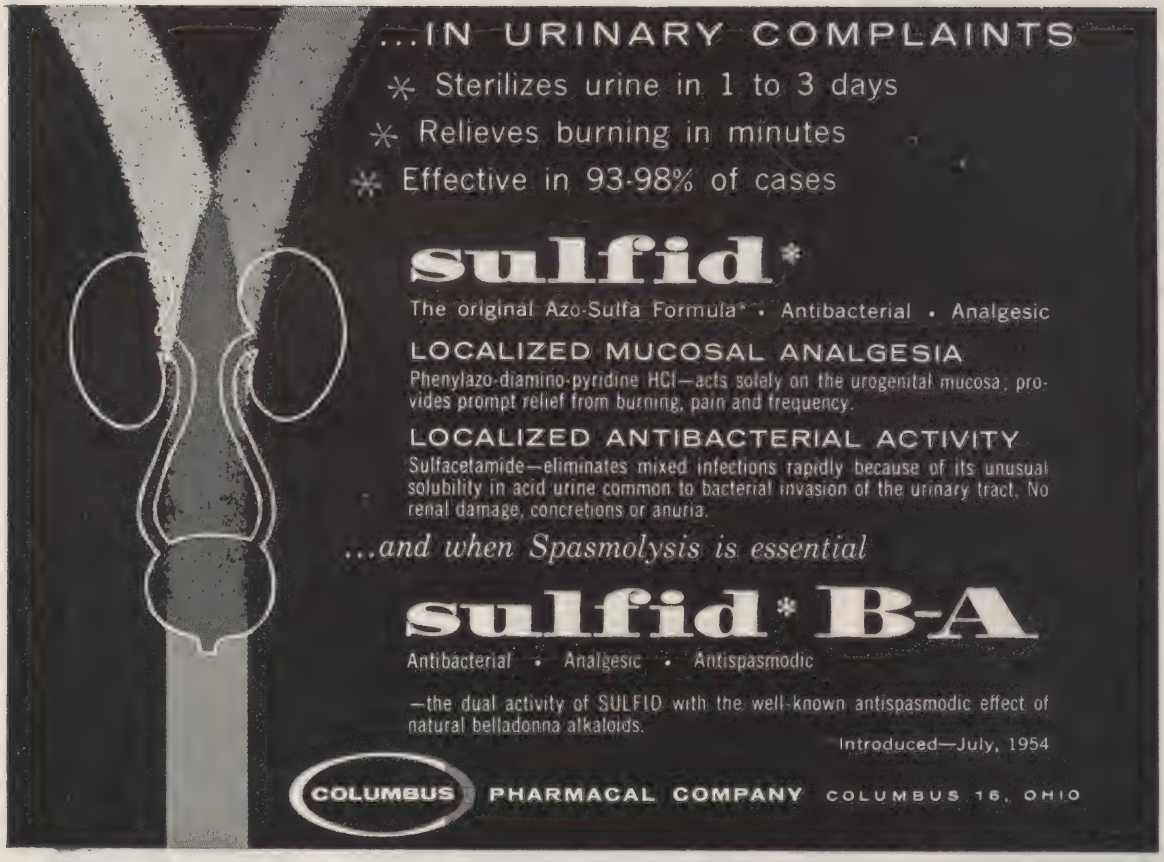
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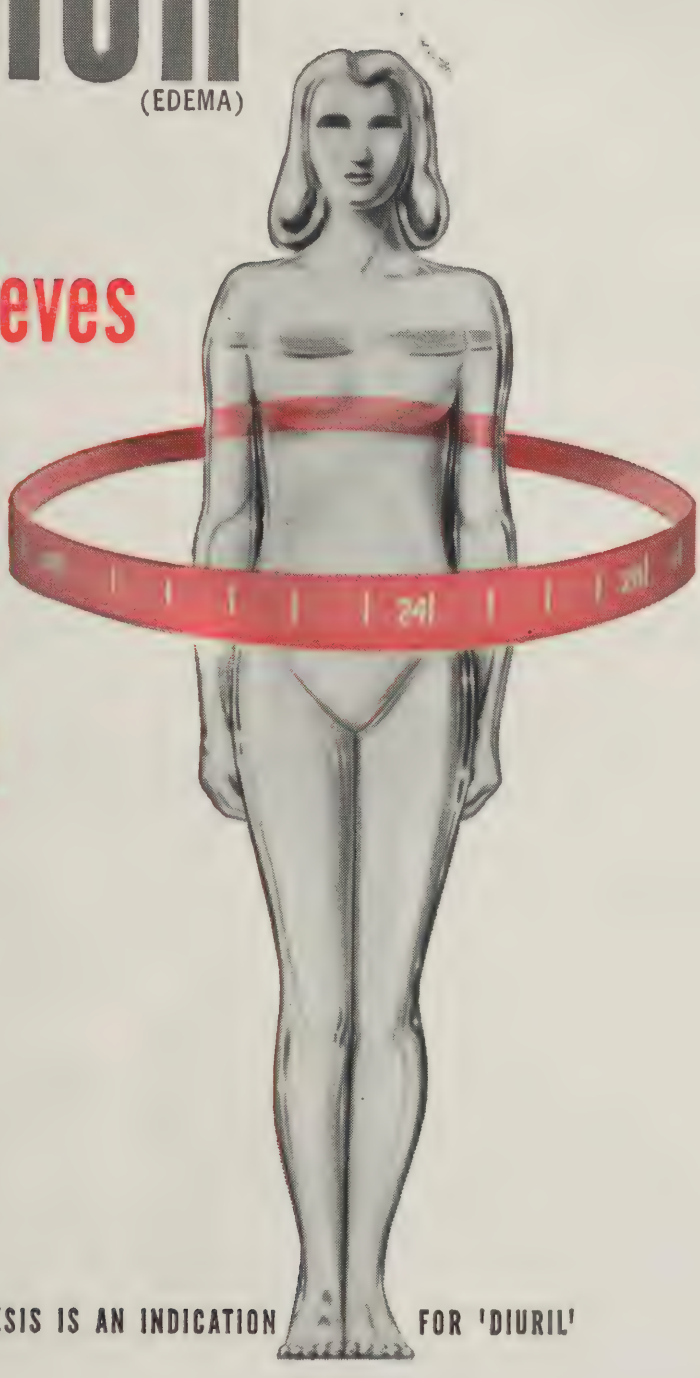
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Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
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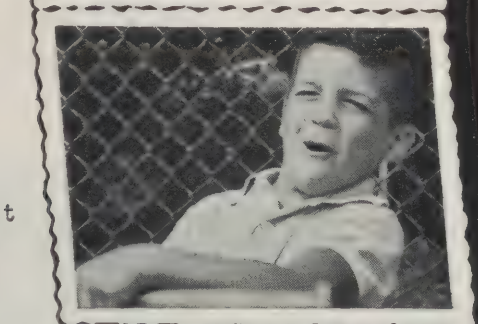
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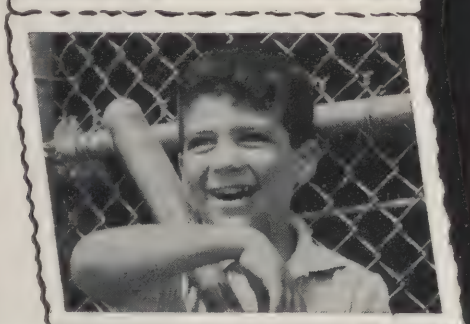
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1. Schuchter, S.L., and Harvison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
2. Alexander, A.G., and Alexander, L.J.: The Nilsach section, *Bull. S. Med. Dermatologists* 5:25, Nov., 1956.
3. Theodore: *Arch. Dermat.* 76:873, June, 1957.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

Ohio Academy of General Practice, Annual Scientific Assembly, October 1-2, Toledo.

University of Cincinnati College of Medicine, Postgraduate Course in Heart Disease, Cincinnati, September 3-6.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

CORRECTION

In the tabulations on page 794, June issue of *The Journal,* an error was made in reporting the total membership of the Ohio State Medical Association as of December 31, 1957. The correct total membership as of that date was 9070.

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Vol. 54 August, 1958 No. 8

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Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

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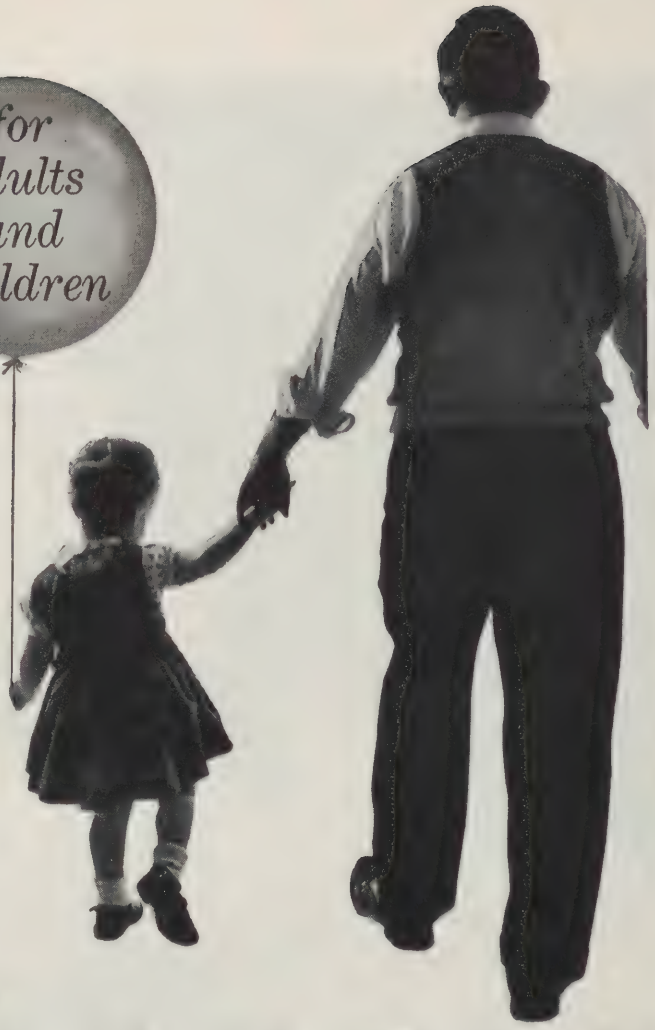
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(Continued on next page)

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MONTGOMERY—Albert V. Black, President, Centerville; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton 2. 1st Friday, Jan., Feb., March, April, May and November; 1st Wednesday, June, October and December.

PREBLE—E. P. Trittschuh, President, Lewisburg; John R. Bowman, Secretary, Eaton. Annual meeting only.

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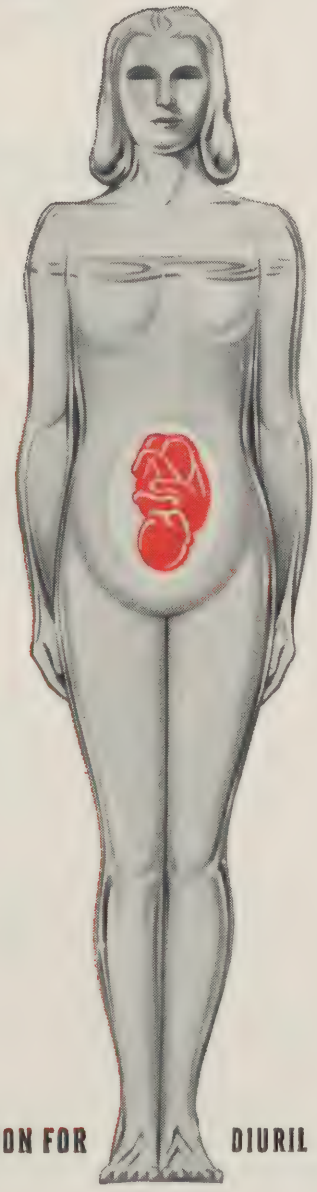
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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Textbook of Pathology: With Clinical Applications, by Stanley L. Robbins, M.D. ($18.00, illustrated, *W. B. Saunders Company, Philadelphia 5, Pa.)* It has been written for students of clinicians with three major goals in mind. First, that the subject matter be presented in a logical, concise and readable fashion, devoid of distracting details. Second, that since pathology requires familiarity with the normal structure and functions of organs, that the major relevant normal features of a tissue or an organ will be briefly cited before the pathology is discussed in order that the reader's mind be refreshed. And, finally, considerable emphasis has been placed on relating pathology to clinical medicine.

Current Surgical Management: A Book of Alternative Viewpoints on Controversial Surgical Problems, by John H. Mulholland, M. D., Edwin H. Ellison, M. D., and Stanley R. Frieson, M. D., with contributions by 76 American authors. ($10.00, *W. B. Saunders Company, Philadelphia 5, Pennsylvania.)* In addition to Dr. Ellison the other Ohio contributors are Drs. Thomas Boles, Jr., H. William Clatworthy, Robert J. Izant, Arthur James, Robert N. Watman, and Roger D. Williams, of Ohio State University, and Drs. George Crile, Jr., and Donald Effler of Cleveland.

With wider knowledge a book of this type is of service and as the editors say in their Foreword, it is curiously a paradox that writings on surgery in a period of relative ignorance could be dogmatic whereas in the present period of great knowledge controversy is accepted. Possible at the beginning of this century to lay down rules for conduct to meet most situations so that the practicing surgeon had only to do what the book said should be done; the need for thinking about individual problems was reduced to a minimum. That has been changed and this book has been designed to meet that change.

An Atlas of the Commoner Skin Diseases, by Henry C. G. Semon, revised with the collaboration of Harold T. H. Wilson, M. D., color photography originally directed by the late Arnold Moritiz, M. D. ($20.00, 5th edition, *Williams & Wilkins Company, Baltimore 2, Md.)* This Atlas has now completed its 22nd year of existence, a fact which testifies that it is a useful addition to any physician's library. With the object of correcting well-founded adverse criticisms the author has secured the collaboration of Dr. Wilson and the two of them have brought out the fifth edition. It contains 153 plates reproduced by direct color photography from the living subjects with a page of comment on the nature and character of the disease and the points illustrated by the photograph. An excellent desk volume for every physician dealing with general medicine.

DeLee's Obstetrics for Nurses, revised by M. E. Davis, M. D., and Catherine Sheckler, R. N. ($6.00, 16th edition, *W. B. Saunders Company, Philadelphia 5, Pa.)* This revision of the time honored classic maternity nursing text represents a major change, not so much in content as in outlook. In the last edition the authors placed new emphasis on psychological aspects of pregnancy. This revision progresses toward the recognition of the indivisibility of the functions of the mind, the body and the emotions throughout the child-bearing experience. There is also an effort to deemphasize the pathological aspects of pregnancy.

Synopsis of Obstetrics, by Jennings C. Litzenberg, M. D., revised by Charles E. McLennan, M. D. ($6.00, 5th edition, *C. V. Mosby Company, St. Louis 3, Mo.)* This edition has been revised by Charles E. McLennan, M. D. of Stanford University and he has introduced important advances in obstetrical thought and practice which have become rather widely accepted in recent years and has deleted whatever appeared outmoded.

Blood and Bone Marrow Patterns, by G. D. Talbott, M. D., Elmer R. Hunsicker, B. S., and John Li, M. D. ($12.00, *Grune & Stratton, Inc., New York 16, N. Y.)* This is an atlas of color photomicrographs showing the blood cell patterns as seen by bone marrow smears in the various abnormal conditions. An excellent reference work for any laboratory.

Optics: The Science of Vision, by Vasco Ronchi, translated by Edward Rosen. ($10.00, *New York University Press, New York 3, N. Y.)* This book presents a revolutionary approach to the whole concept of optics which redresses the balance of the science after centuries of its dehumanization by mathematics and physics. It incorporates the validity of subjected measurement after totally reorienting the subject. It challenges the mathematical concept of optics and goes beyond ophthalmology.

Gynecologic Therapy, by William Bickers, M. D. ($4.25, *C. C. Thomas Publishers, Spring-*

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field, Illinois.) This book has been born out of the apparent need for interns and residents who are confronted for the first time with the responsibility for clinical diagnosis and treatment of gynecologic patients. The clinical history, the physical findings, the laboratory diagnostic tests and the therapeutic regimes are presented in the style of the authority of the best opinion of the day.

The Chemistry and Biology of Purines: A Ciba Foundation Symposium, by G. E. W. Wolstenholme, M.D. and C. M. O'Conner. ($9.00, *Little, Brown and Company, Boston 6, Mass.)* The study of purines has proceeded until recently along two lines, from the approach of the synthetic chemist and the viewpoint of the biochemist. Now, with an exchange of views a collaborative reorientation is producing valuable results. This symposium therefore is an important record of the current thought on purines voiced by workers in both disciplines. Recent advances have been made in the biosyntheses of nucleic acid, and the knowledge gained in elucidating this problem opened the prospects of fundamental research in therapy. Considerable progress has also been made in the enzymology of the purines and their complex derivatives. One or two drugs of some clinical value have already been discovered as a byproduct of this particular line of investigation.

Blood Tests In Mental Illness: Papers and Discussion Presented at the Annual Scientific Conference of the Brain Research Foundation, by Frederic Gibbs. (Apply. *Brain Research Foundation, 600 S. Michigan Ave., Chicago 5, Ill.)* This 1957 Scientific Conference provided an opportunity for those interested in Dr. Akerfeldt's work and engaged in simple studies to consider his findings and compare them with their own and consult together regarding the relationship between certain disorders of body chemistry and mental disease.

The Person With Epilepsy at Work: Report 36, formulated by the Committee on Psychiatry and Industry. (25 cents, *Group for the Advancement of Psychiatry, 1790 Broadway, New York 19, N. Y.)* It gives the latest thought to the problem of convulsive seizures and the employment of these million and a half of our citizens, so afflicted, in industry. It is a part of the general consideration of the employment of the physically handicapped.

A Woman Doctor Looks At Love and Life, by Marion Hilliards. ($2.95, *Doubleday and Company, New York 22, N. Y.)* The chief of obstetrics and gynecology at the Woman's College Hospital in Toronto is the author for this manual for women. It is designed to help women to find health knowledge which leads to inner peace and successful zestful living. Whether a woman is frightened or simply perplexed or bothered by her problems the author gives her outspoken advice and realistic answers from her authoritative point of view, both as a woman and as a physician. On the other hand it is not a series of sermons. It is lively, written of case histories and anecdotes.

The Adrenal Cortex, by I. Chester Jones. ($7.00, *Cambridge University Press, New York 22, N. Y.)* The various products of the adrenal cortex play an essential part in the functioning of living creatures and very much has been learned about this organ since the time some 58 years ago that your reviewer was studying the effects of this organ's removal on the gasseous exchange of the cat. It has long been a major subject of study and experimentation for endocrinology. This is the first monograph to give a comprehensive account of the workings of the cortex in all of the various biological species among the vertebrates.

Rheumatic Diseases, Rheumatism and Arthritis, by Henrich G. Brugsch, M. D. ($10.00, *J. B. Lippincott Company, Philadelphia 5, Pa.)* The chief of the Arthritis Clinic in the Boston Dispensary has given us an up-to-the-minute practical comprehensive work on the overall management of the patient with joint disease. It covers as well etiology, diagnosis, and the clinical picture and prognosis of each disease discussed. For the purpose of this book, the diseases which are known to be definitely of rheumatic origin have been separated from the nonrheumatic, separate chapters have been devoted to the so-called collagen diseases and then such things as bursitis, neuritis and ruptured intervertebral disc and other bone diseases.

For Teen-Agers Only: The Doctor Discusses Marriage, by Frank Howard Richardson, M. D. ($2.95, *Tupper and Love, Inc., Atlanta 2, Ga.)* This is a private series of talks with young people who are facing, or should be, the subject.

Signs and Symptoms, Applied Pathological Physiology and Clinical Interpretation, edited by Cyril Mitchell MacBryde, M. D. ($12.00, 3rd edition, *J. B. Lippincott Company, Philadelphia 5, Pennsylvania.)* This text approaches diagnosis in the same way that most of us do, through the analysis and interpretation of presenting signs and symptoms. In each chapter a major symptom is discussed. The mechanism of its production clarified by the light thrown upon it by anatomy, physiology, pathology, chemistry or psychology, its correlation with other symptoms and the physical

(Continued on Page 1007)

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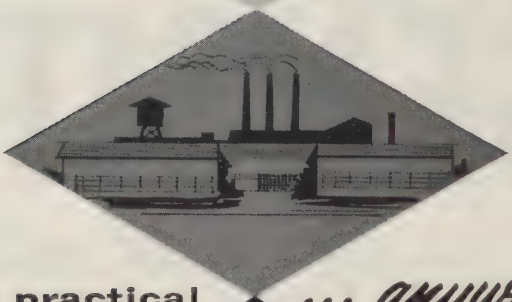
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(Continued from Page 1004)

and laboratory findings described. The book has been thoroughly revised and brought up-to-date in all chapters.

Hutchison's Clinical Methods, by Donald Hunter, M. D., and R. R. Bomford, M. D. ($6.00, 13th edition, *J. B. Lippincott Company, Philadelphia 5, Pa.)* This guide has been servicing physicians and students for the past 60 years. This edition has been condensed by about 20 pages but nevertheless brought completely up-to-date and still serves a useful purpose for which Sir Robert Hutchison intended it.

Fundamentals of Immunology, by William C. Boyd. ($10.00, 3rd ed., *Interscience Publishers, New York 1, N. Y.)* This book reflects the enormous advances that have been made recently in the subject. It gives a clear understanding of the basic principles of immunology and is of value not only to the student but to the research worker and to the physician practicing in this field.

Atlas of Clinical Endocrinology; Including Text of Diagnosis and Treatment, by H. Lisser, M. D., and Roberto F. Escammilla, M. D. ($18.75, illustrated with 148 plates free in color, *C. V. Mosby Company, St. Louis 3, Mo.)* It is intended to give busy practitioners more knowledge about the intricacies of steroid chemistry and the details of animal experiments that are pushing back the frontiers of our ignorance in this field and it is intended also for those who would like to understand more about the application of what we know to human ecology. The authors with their extensive experience present most useful examples from out of their storehouse and in this way bring us a book for clinicians endorsed by E. Perry McCullagh, M. D., of the Cleveland Clinic.

Blood Transfusion in Clinical Medicine, by P. L. Mollison, M. D. ($9.00, 2nd edition, *Charles C. Thomas Publisher, Springfield, Ill.)* In this new edition most of the chapters have been rewritten to take into account the many advances of the last five years and also much of the material has been rearranged which seems appropriate in the light of new discoveries.

Modern Therapy in Neurology, by Francis M. Forster, M. D. ($12.00, *C. V. Mosby Company, St. Louis 3, Mo.)* The appearance of this book is a milestone in the progress of our fight against the disease. Up to recent times the specialty of neurology has been justly criticised for its lack of interest in treatment. It was the concensus that neurology was concerned mainly with the intricacies of localization of lesions and that after a diagnosis had been established there was usually no effective therapy. In recent years as the diseases of the nervous system began to have a biochemical and immunological background it has been possible to develop a considerable armamentarium and this book presents the latest with each chapter being in the hands of an outstanding man in the field. For instance, the use of tranquilizing drugs in neurology is well discussed by Howard D. Fabing of Cincinnati.

Industrial Toxicology, by Lawrence T. Fairhall. ($10.00, Second Edition, *Williams and Wilkins Company, Baltimore 2, Md.)* This encompasses in one compact reference book all of the classified information and discoveries of importance that have been made available. This edition also gives a completely revised digest of the currently available knowledge in this field.

Voluntary Health Insurance in Two Cities: A Survey of Subscriber-Households, by Odin W. Anderson and staff, National Opinion Research Center. ($5.00, *Harvard University Press, Cambridge 38, Mass.)* This determines scientifically the impact of uninsured illness on the use of services and facilities for sickness. The 200 drug companies who sponsor the foundation backed this in order to give underwriters data with which to measure accurately the accomplishments of present-day hospital and medical prepayment and insurance coverage.

565 Industrial Compensation Decisions, by Richard F. Gonda, J. Arlen Marsh and Ivan W. Louis. ($12.50, *Occupational Hazards Magazine, 812 Huron Road, Cleveland 15, Ohio.)* This work presents a condensed version of Workmen's Compensation cases completely cross-indexed for ready reference.

The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence, by Lawson Wilkins, M. D. ($17.50, 2nd edition, *C. C. Thomas Publisher, Springfield, Ill.)* This book has been written to help the clinician to understand, diagnose and treat these conditions. In recent years the medical profession has become much more familiar with the subjects through the wide publicity accorded recent advances. Now there is an earnest desire for more complete information concerning the chemistry and physiology of hormones and for an evaluation and interpretation of some of the newer work.

Benjamin Waterhouse and the Introduction of Vaccination; A Reappraisal, by John B. Blake. ($4.00, *University of Pennsylvania Press, Philadelphia 4, Pa.)* A revelation in the light of fresh material never before used in this connection, the lectures on the History of Medicine at Yale were through the traditional picture of Waterhouse.

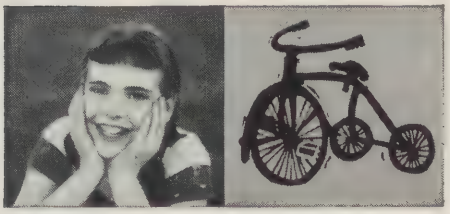
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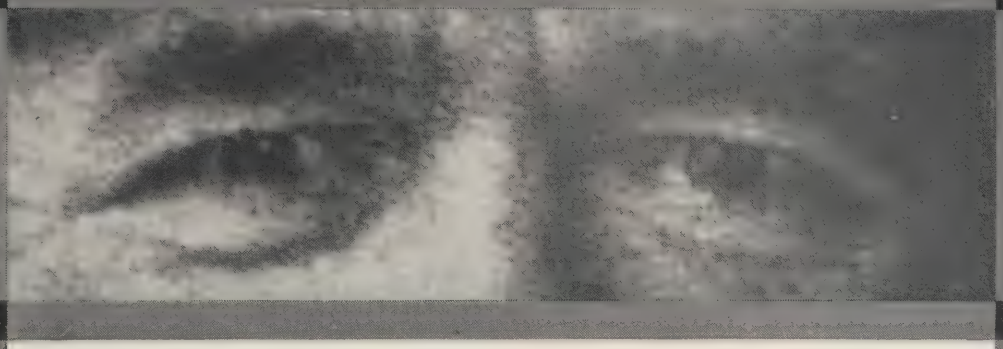
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Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: A Clinical Evaluation of Ectylurea (NOSTYN®), in press.

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Social Security for Physicians . . .

Material Pro and Con on This Subject in This and September Issues of *The Journal*; Poll To Determine Opinion of OSMA Members Will Follow

THE HOUSE OF DELEGATES of the State Association, at the April Annual Meeting in Cincinnati, adopted a resolution calling for a poll of OSMA members on the question of whether or not physicians should be included in the Federal Social Security Program. This poll will be conducted during the month of October.

The House of Delegates further directed that *The Journal* should present in each of three issues (July, August and September) selected material and comments both for and against the inclusion of physicians under Social Security. The first of this material was presented in the July issue, beginning on page 868. Following is additional material on both sides of the question.

Members are advised that opinions expressed by the writers are those of the authors and do not necessarily reflect opinions of officials of the OSMA or staff members of *The Journal*.

Arguments For

"THE Case for Social Security" was the subject of an article authored by Dr. H. Feilding Wilkinson in the October, 1957, issue of *Medical Economics*. The article read as follows:

Since 1935, when the Social Security Act became law, the medical profession has stood at the top of the list of those opposed to it. The profession is still at the top. But it stands there entirely alone—the sole major occupational group in the country not now covered by Social Security.

Do we doctors *like* being alone? Apparently nearly three out of five of us think we do. The most recent national survey (reported by *Medical Economics* in September, 1956) showed 59.8 per cent of self-employed physicians opposed to compulsory coverage for themselves.

But is also showed 40.2 per cent in favor. So more than two in five of us *don't* like being alone. That's a substantial minority. And it has substantial economic reasons for the stand it takes.

The same can't be said, in my opinion, for the doctors who oppose Social Security. After listening to a good many of them, I'd say that their objections are based more on myth than on fact. And they're often so glibly stated—even when one of them virtually contradicts another—that one suspects they've been heard or read somewhere and that they're being parroted without benefit of thoughtful consideration.

What are some of these often repeated objections to Social Security? I'll state them in the doctors' own words—and, at the same time, I'll

(Continued on Page 1011)

Arguments Against

By Charles W. Pavey, M. D.,
Columbus, Ohio

THERE are a great many cogent reasons why the medical profession should shun inclusion in the Social Security system. These reasons are ethical, philosophical and practical but none are as important and meaningful to the medical profession as the inescapable association between Social Security and socialized medicine.

Those who argue for socialized medicine contend that it is essential to the nation's health because they say the average family cannot afford to make financial provisions for their medical care and hospitalization. This despite the fact that such provision would take a smaller part of the family budget than liquor, automobiles, amusement and other far less essential things. Most of the medical profession deny this contention and claim that the average American family does not need governmental financial assistance to pay for medical care and they contend furthermore that such methods constitute socialized medicine and are not in the public interest. Most of us will agree that this is correct. On the other hand, it is utterly inconsistent to argue that socialized medicine is bad but socialized power, transportation, manufacturing or insurance is good. If the medical profession demands inclusion in the Social Security system then we can be assured that the politicians will point out to us that we don't object to socialism when we are the beneficiaries and they are sure to say that our objections to socialized medicine are obviously insincere and

(Continued on Page 1011)

Arguments For (Cont'd)

tell you why I believe these doctors are misinformed about the Social Security system.

Is It Fraudulent?

"It's financially bankrupt, a fraud."

Those opposed to Social Security back up this charge by alleging that the contributions taken in are being spent "right and left" by the government. Social Security, they say, is just an excuse for unbridled Government spending—"and there'll be no money left when growing numbers 65-year-olds become entitled to it."

No money? Financially bankrupt? Well, there's nearly $23 billion surplus in Government bonds in the Old Age and Survivors Insurance Trust Fund. If ever there *were* a dangerous drain on the fund, Social Security tax rates could easily be raised. All it takes is a vote of Congress.

Meanwhile, far from being dribbled away, the funds already collected are constantly drawing interest. They've already earned some $3 billion in interest.

Actuaries Were Right

"It's actuarially unsound."

Actuaries are the mathematicans who use mortality tables, loss ratios, and other data to determine rates for various types of insurance. In the case of Social Security, they did their job well: The size of the fund's current surplus, the changing rates of income and outgo, are falling into almost the exact pattern that was anticipated more than twenty years ago.

I'd call that actuarial soundness rather than the reverse.

"It's a Government handout."

Since 1936, Social Security has taken in some $20 billion more than it has paid out. This sum, plus about $3 billion in interest, is invested in U. S. bonds. These are the same bonds, remember, in which your private insurance company has invested a good percentage of its own reserve funds.

If a private insurance carrier had a surplus of $23 billion out of a total income of $30 billion over a twenty-year period, the cry would be "robbery," not "handout."

But lest you conclude it *is* "robbery," let me explain something else:

25-Year Reserve

The $23 billion excess is necessary as a reserve fund. It will be needed before the Social Security fund reaches a point of balance between income and outgo. During the next twenty-five years, all those extra billions will be used up in payments to

(Continued on Page 1012)

Arguments Against (Cont'd)

based on selfishness rather than on any ethical or philosophical objections to socialized medicine or Socialism per se. They are sure to say "you doctors are quick to ask for government security but you would deny to others the equally important government medicine." And when they do say that, it will be a hard argument to counter. It behooves us to note also that most of the organized groups, such as The Physicians Forum, urging inclusion of M. D.'s in Social Security have also advocated socialized medicine. The relationship between socialized medicine and inclusion of M. D.'s in Social Security seems to be lost on many physicians but we can be certain that the proponents of socialized medicine understand it quite clearly.

The Door Swings in

Too many doctors advocating inclusion do not fully understand that they are proposing a dangerous step that will be forever irrevocable. If further and more extensive experience would prove beyond doubt that inclusion might be desirable, we can always get in but once we are in, no matter how grievous an error it may prove to be, we can never get out. Similarly many physicians are not fully aware that there is no contract nor any actual ceiling on premiums. There is a projected plan for graduated increases up to a certain point but this proposed scale has already been altered several times to allow for additional dubious benefits which will be increased every election year and it is entirely possible that the rate will go to 10 per cent of the first $20,000 of earnings. If this should happen the average doctor would be paying $2000 per year for less insurance than the laborer with a larger family would be getting for $300 or $400. On top of that benefits will be determined by Congress from year to year. There is no contract. No one knows how much his premium will buy in benefits until he goes to collect. This is Communism in action! Taking from each according to his means and giving to each according to his need! A fundamental principle of Marxism.

Changing the Rules

The Social Security Administration has already "welshed" on its promises a number of times. In 1935 the act assured the 33,000,000 people required to pay into the fund a permanent coverage after five years. In 1939 this was arbitrarily increased to 10 years. The 1935 act guaranteed the taxpayer or his estate his money back if he did not get it in annuities. In other words the original act was in effect an enforced savings

(Continued on Page 1012)

Arguments For (Cont'd)

new beneficiaries. After that, as tax rates rise according to schedule, the fund will be completely carrying itself.

"I can take care of myself without Social Security."

Are you sure? In Los Angeles, over 100 doctors and other members of medical families are being taken care of by the Los Angeles County Medical Association. A similar situation exists in New York City. Undoubtedly, these indigent physicians once assumed that *they* could take care of themselves.

Better Than Charity!

If it weren't for the out-of-pocket charity of their colleagues, such men—or their widows and children—might be on public assistance rolls. Charity has been a godsend for them. But how much more of a godsend would Social Security have been!

It's fine to be proud of one's independence. But as a pretext for rejecting Social Security, such pride seems a trifle naive. The retired bank president who lives next door isn't too proud to accept his $108.50 a month. The business executive who died last year would be glad to know that his already well-off widow and children are getting Social Security payments of $200 a month.

Would your widow be too proud to take such payments? Don't be too sure. Don't be too quick to deny her and your children 2,400 nontaxable dollars a year.

Protects Your Heirs

"It's a gyp: You get nothing if you die before 65."

Of course *you* don't. But your beneficiary gets plenty. When a person who's covered by Social Security dies—whether before or after 65—his survivors can receive up to $200 a month. Even his parents, if dependent, can get substantial monthly benefits as long as they live.

This feature alone can be worth up to $35,000. Is that bad?

"It's a gyp: You get nothing after 65 unless you quit working."

True, up to a point. But those who protest fail to understand the real purpose of Social Security. It's not a substitute for private retirement plans. It's to save people from the humiliation of going on public relief rolls. In addition, it's intended to furnish a foundation upon which to build your own retirement fund—*if* you so desire.

The average age of retirement under Social Security at present isn't 65; it's 69. Obviously,

(Continued on Page 1014)

Arguments Against (Cont'd)

plan and as such far more defensible than the present plan with its built-in politically inspired vote buying aspects. This promise was kept in a half million cases and then in 1939 Congress wiped out this part of the agreement to 33,000,000 others who had been given the same promise. They were not allowed to withdraw from the game now that the rules were changed and in the ensuing 13 years seven million of their number died without refund or pension payments.

Anyone interested in being honestly and accurately informed on Social Security should read a little inexpensive book by Dillard Stokes entitled *Social Security Fact & Fancy* (Henry Regnery Company, Chicago, $4). In view of the fact that Social Security "premiums" might very well cost you from $8,000 to $40,000 in the next 20 years depending on rates and benefits yet to be determined you can hardly afford to cast a vote without first being informed.

The argument so often presented that since "Social Security" must inevitably be subsidized by the income tax and since we help pay for it anyway we might as well get in on it is comparable to saying that since we give to the Salvation Army we ought to get in the line for a free basket of groceries at Christmastime.

The Social Security system as it is presently set up and operated and as is demonstrated by every session of Congress is the most colossal vote buying device in history. To buy votes with private funds is a crime. To buy them with public money is rapidly becoming a standard order of procedure among certain legislators and if we allow ourselves to become the recipients of such covert bribes we jeopardize our positions as members of an idealistic and honored profession.

One of the often heard arguments in support of inclusion of doctors in Social Security is that "it's just insurance." Actually the Supreme Court has held on the representations of the government's own lawyers (May 24, 1937) that it is not insurance but charity. The so-called premiums are actually income tax on the worker, excise tax on the employer and the disbursements are relief payments.

"Socialized" Security

Charity and governmental Social Security are intended for those who cannot and those who will not make provision for their own old age. We as physicians fit neither of these groups. If we are indeed the proud, independent, individualistic breed we represent ourselves as, to the public, if we really hate Socialism for the evil that it is,

(Continued on Page 1014)

Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle



Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

*Reg. U. S. Pat. Off.

Arguments For (Cont'd)

many Americans forgo benefits for several years for the privilege of earning more while they can. Nor do you hear complaints from such persons, even though many of them have been paying into the fund for over twenty years. They'll get theirs back in time with plenty of interest—and they know it.

From 65 to 72, incidentally, you can earn up to $1,200 a year and still get full benefits. Over 72, you get your Social Security payments no matter how much you earn.

Every Bit Helps

"Benefits are too small to bother about."

Is $162.50 a month for yourself and your wife really so insignificant? Maybe it seems so to the doctor who's a great financial success. But such a doctor may be overlooking this: Those extra dollars are all *tax-free.*

Figure out what that's worth if you're in the higher brackets.

"It's unfair: It allows some persons who've paid in almost nothing to get full benefits."

True, some people have obtained up to $10,000 or $15,000 worth of coverage for contributions of only $75 to $100, while others have contributed far more and received far less. But the same things happen with private insurance. Would you call life insurance unfair simply because the family of a policyholder who dies early gets a greater "bargain" than does the family of a man who goes on living and paying premiums?

Why, then, raise such an argument against Social Security?

'Weakens Character'

"It violates American traditions and ideals."

There are many variants of this charge: "It weakens national character . . . It restricts and threatens individual initiative . . . It destroys self-respect and independence of spirit . . ."

Nonsense! It hasn't done any of these things to those thousands of our fellow-countrymen who, preferring work to benefits, have boosted the average retirement age under Social Security to 69.

Would It Backfire?

"It invites socialized medicine."

This objection stems from some doctors' fears that the public would react thus: "Oh, so you medical people want state-sponsored security, do you? Well, then, we want state-sponsored *medical* security.

Conceivably this could happen. But it's most unlikely. Some 120,000,000 Americans already

(Continued on Page 1015)

Arguments Against (Cont'd)

then we want no more part of socialized insurance than we do of socialized medicine. A vote for socialized insurance is a vote for socialized medicine.

Among the more vocal proponents of including doctors in Social Security is The Physicians Forum, an organization that has long advocated socialized medicine and that was declared to be a Communist front by the California Un-American Activities Committee. While many doctors profess to be unable to see the connection between Social Security for physicians and socialized medicine we can be sure that the relationship is quite clear to The Physicians Forum and that they visualize such inclusion as an incomparable stepping stone to their real goal of socialized medicine. This is a rather small organization and one might well ask where they got the very large amount of money required for the nationwide mailings they have put out advocating inclusion of doctors in Social Security.

Anyone who can even contemplate this proposal with equanimity must be blissfully unaware of its real nature. Here we have a new type of income tax, a tax on wages or earnings without deductions and in all probability without limit. It is morally certain that the politicians will continue to use Social Security to buy votes which means it will be expanded in all manner of fantastic ways and while the rates are bound to increase what is even more certain is that the base amount will go up and up simply because that will antagonize fewer taxpayers and lose fewer votes. The base may very well be expanded to $20,000 per year or above, and the rate could reach 20 per cent or more as it has in some European and South American Countries.

Welfare (?) State

The Welfare State has never succeeded anywhere. It has nowhere abolished poverty nor raised the health standard of a nation. It undermines morale, limits liberty and tends to destroy thrift and initiative while creating a bureaucratic autocracy. Year after year we must defend ourselves from this monstrous degradation—but if just once we relax our vigilance, just once we let our guard down we are in forever, irrevocably in. We will never again have a chance to vote on it, there will be no chance to rectify our error, no forum for our complaints, we will have joined 55,000,000 others behind the bureaucratic iron curtain forged out of their own complacency and indifference.

The normal insurance program contemplates

(Continued on Page 1015)

Arguments For (Cont'd)

have some kind of voluntary health insurance. They've turned to voluntary sources for their medical security. Unless these sources fail them, they're not likely to turn away.

There's a far greater danger than that of inviting socialized medicine. It's the danger of permitting the public to conclude that doctors make so much money they can easily take care of themselves without a "paltry hundred or two a month" after they reach 65.

That isn't true—but the public wouldn't know it from the way the medical majority has been acting.

Personally, I think there's going to be a new medical majority before long. The arguments against Social Security are too thin. The economic facts that constitute the argument in favor of it are too substantial.

Two months ago in *Medical Economics,* the director of the AMA Law Department predicted that "Congress will force the medical profession under the Social Security Act on a *compulsory* basis within the next five or ten years."

I wouldn't dispute this. I'd simply ask self-employed physicians to give serious consideration to a two-word question: *Why wait?*

* * *

By Geo. O. Cummings, Sr., M. D.

"I am in favor of Social Security for Physicians," wrote George O. Cummings, Sr., M. D., Portland, Maine, in the December, 1957, issue of *The Journal of the Maine Medical Association.* Dr. Cumming's article reads as follows:

I am interested in securing Social Security for physicians.

I am 66 years old and will not benefit from Social Security unless I can work six quarters.

I receive $135 a month from an annuity with the John Hancock Insurance Company which cost me $500 a year for 25 years, a total of $12,500. If Social Security had been instituted 25 years ago, I would have paid in a total of $5,496.75 and I would receive at the age of 65, $162.80 each month for myself and my wife.

Under my annuity, if I die, my wife will receive a lump sum, the unpaid balance of the principal. Under Social Security, she would receive for life, $81.40 a month if she started to receive payments at the age of 62, and $108.50 a month if she started payments at the age of 65.

Social Security is the cheapest protection that you can buy for you and your wife.

The following quotation is from a pamphlet

(Continued on Page 1018)

Arguments Against (Cont'd)

premium payments at the rates which will cover anticipated benefit payments, actuarially determined, and operating cost plus some reserve to take care of possible inaccuracies in the actuarial figures but the Department of Health Education and Welfare cheerfully admits that it does not operate on this system and that there is no relationship between what an individual pays and what he may receive. This system will continue to work so long as 50 or 60 million people are paying in and only seven or eight million receiving benefits but this is a ratio that is constantly shifting in the direction of more and more beneficiaries in proportion to the number of taxpayers.

Big Promise — of What?

There is very great risk that the day may come when this tax burden will be utterly insupportable and the hapless taxpayer may finally revolt and when that day comes there is a possibility that those who had anticipated receiving Social Security will instead be notified that lack of revenue precludes the fulfillment of poorly funded promises of previous administrations, or, and what is more likely, they will be paid off at the rate promised them at the time they went into this system with dollars that are so inflated that their buying power will be cut to practically nothing. Social Security as it is at present set up and at present being charged is not insurance at all but nothing more or less than another income tax which the government has tried to make moderately palatable by promising something in return and you will note that we say promising, not guaranteeing. The Social Security officials will admit that none of the money in the so-called trust fund that has been accumulated since the start of this system by the working people and their employers will be available for benefits to them when they retire. Everybody in the group still working will be obliged to depend on future taxes to pay their so-called benefits. The cynical unprincipled argument so often presented as a reason why you should want to be included in Social Security is that you will be paying in at a low rate, lower than it will ever be again, for a short time, and then will be paid back generously with somebody else's money. As Christians and Americans we shouldn't be interested in living our declining years on somebody else's money. What you get without earning someone else must earn without getting, for our government cannot give to any of us what it does not first take away from some of us. Living as a parasite on the earnings of other men's labors is looked upon with considerable disfavor by these

(Continued on Page 1018)

Faster rehabilitation in

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

a

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa.

Rheumatoid Arthritis

multiple compressed tablets

MEPROLONE®

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation...

c

Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.



MEPROLONE is a trade-mark of Merck & Co., Inc.

Arguments For (Cont'd)

"Nine Sound Reasons," published by the Committee on Social Security for Physicians, The Physicians Forum, 510 Madison Avenue, New York 22, New York. Anyone who desires more information should obtain the pamphlet from them. It is clear and brief.

1. Old Age and Survivors Insurance (OASI) offers better value for your insurance dollar than any private company in the United States. It provides three-way coverage—life insurance, disability benefits and retirement income. To get the same benefits from private companies can cost from $6,500 to $25,000 more.

2. Among the 70,000,000 Americans under Social Security are dentists, lawyers and other self-employed professionals; bank presidents and business executives in top-income brackets; physicians employed by hospitals, medical groups and private industry. Why should self-employed physicians be excluded?

3. OASI coverage requires no physical examination. No one is excluded or asked to pay higher premiums because of existing disability, ill health, occupational hazard or advanced age .

4. OASI benefits are entirely tax free, and are paid without regard to income derived from investments, private insurance or annuities. These benefits could provide a substantial foundation in planning your family's security.

5. OASI contribution rate is uniform for all self-employed persons, regardless of other income or age. You pay a fixed rate only on the first $4,200 of earned income. For years 1957-1959, the rate is 3⅜%—or a maximum of $141.75 annually.

6. For the young doctor, survivor's benefits of OASI are especially important. In the event of his death, his widow and children under age 18 receive a maximum of $200 a month.

7. For the older doctor (including those practicing at age 65 or over), OASI retirement benefits

Cost of Retirement Benefits Under OASI* Compared With Private Insurance Companies
(For husband and wife)

If you enter OASI in 1958 at age of	You would pay OASI taxes totaling (by age 65)	Same benefits from private companies cost you at least	Your loss because of exclusion from OASI
30	$8,174.25	$14,700	$ 6,525.75
35	6,835.50	16,300	9,464.50
40	5,496.75	18,000	12,503.25
45	4,158.00	19,900	15,742.00
50	2,882.25	22,000	19,117.75
55	1,764.00	24,400	22,636.00
60	803.25	26,000	25,196.75

*Cost of OASI also covers survivors insurance and disability.

are a welcome addition to his retirement income. At age 72, he would get full benefits, regardless of

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Arguments Against (Cont'd)

self-same people that are advocating that we adapt this self-same idea to Social Security.

Leaning on Progeny

We should like to also call your attention to the fact that simply making this swindle legal by no means has made it moral. Just ask yourself does this generation have any moral right to place the burden of its future on the shoulders of its own sons and daughters? This is a moral problem even more than a financial one. Our children are destined to be the innocent victims of our decision, and even though they may pass on a burden to their children thereby doing to their progeny what we are doing to ours, we can scarcely be proud of being a part of a generation which, by its example, teaches its children that such an act is right.

For anyone to vote himself benefits that he knows in advance he will not pay for is comparable to charging something to someone else's account without their knowledge or consent. That any member of the medical profession would attempt to gain for himself benefits to be paid for by strangers as yet unborn seems utterly incompatible, with the high ethical standards that we presume to maintain in our professional lives.

It seems quite apparent that the architects of Social Security have engineered it in such a way that we must all ultimately become wards of the State whether we want to or not and their program is aimed at someday taking away from us all of our earnings and giving us back only enough to keep us slaves to the ever-increasing power of the State. As a matter of fact we are already far closer to the realization of that aim than most of us want to admit.

* * *

By Ben Arnoff, M. D.,
Columbus, Ohio

The doctors of Ohio have before them for consideration two plans for retirement, disability benefits and benefits for the protection of their families in case of death.

PLAN NO. 1
THE SOCIAL SECURITY PLAN

What are the benefits?

A. **Retirement**—at age 65 would receive $108.50 per month.

1. **If**—you paid into the fund for at least 1½ years.

2. **If**—you earn less than $80 per month.

B. **Survivors benefits paid to widow.**

1. **If** there is one child under 18—benefits to be paid only until child is 18.

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Arguments For (Cont'd)

his earnings. At age 50 or over, retirement benefits are now provided for the completely disabled.

8. Roughly 35 per cent of all self-employed physicians listed in the AMA Directory have at least some credited earnings under OASI, according to a sample survey by OASI in 1955. They acquired these credits either before entering private practice or by part-time employment while in private practice. Also, physicians who served in World War II are entitled to OASI credits. These credits may be lost or the benefits curtailed unless self-employed physicians are included under the Social Security law.

9. OASI benefits have been adjusted to cushion the effects of inflation. In 1940, maximum monthly benefits for an individual were just over $40. Today, they are $108.50—an increase of more than 150 per cent! Private insurance companies have not kept pace with inflation.

* * *

By Charles S. Higley, M. D.

The following article was published in the November, 1957, issue of the *Cleveland Academy of Medicine Bulletin*. It was written by Dr. Charles S. Higley:

The physician in private practice stands alone in his private economic affairs today. Current figures show that of the 65 million employed and self-employed individuals in this country 59 million are now covered by Social Security. Of the 6 million not covered, 3½ million have earnings insufficient to qualify and the majority of the remainder are covered by other retirement programs. Self-employed physicians are the only remaining professional group not receiving the benefits of coverage by Social Security—now known as Old Age and Survivors insurance or OASI. All other self-employed professional groups including lawyers and dentists are a part of the program at their own request.

This omission of physicians is no accident. It is the result of vigorous and expensive lobbying by the American Medical Association. Its House of Delegates again in June 1957, in a spirit of "father knows best," decided that its members did not, or should not, desire to be included in OASI and ignored the requests of a number of state delegations to change its position. The fact remains that thousands of physicians in private practice, who have given serious thought to this matter, have come to the conclusion that OASI is a bargain as a part of their disability and retirement programs.

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Arguments Against (Cont'd)

2. If there are more than two children under 18 years of age—no benefits paid for more than two children.

3. If widow remarries benefits are discontinued.

4. If childless widow or no children under 18 years of age—no benefits paid until widow reaches age 62.

5. If no survivors—**no benefits paid to anyone** (unless parents are dependent on deceased). **All monies paid into fund become the property of the government.**

C. **Disability benefits.**

1. If under specified circumstances you become permanently and totally disabled certain benefits will be paid.

But, the "issuing company" has the sole right to change any of the above "benefits" at any time without any notice and the "insured" has to accept any change and without any recourse and **has no right to drop out of the plan once it is accepted.** However the "issuing company" can deprive the individual of any benefits it so desires. Furthermore the amount of "benefits" depends also on the amount of money available in its funds for disbursement at any given time. The sole judge of any controversy over the disbursement of any "benefits" shall be the "issuing company"—and its verdict is final.

What does it cost?

1. The cost will vary—increasing ¾ per cent every five years until 1975 and from then on it will be $267.75 per year.

2. All men becoming doctors in 1975 will pay $267.75 per year until such time as the "issuing company" shall decide to raise the rates.

3. The "issuing company" has the sole right to change this rate at any time it so desires without showing cause, without increasing "benefits" and the insured has no recourse and no right to cancel policy once it is issued.

4. **There is nothing implied in this contract to guarantee any payments to anyone nor to guarantee that the rates will be fixed as of date of issue.**

5. In order for the above "benefits" to become effective, not only every physician in the State of Ohio must pay the "premiums" prescribed but also every physician in these United States—whether or not he desires such a policy. **Further once the plan is accepted it cannot under any circumstances be cancelled by the insured.** The

(Continued on Page 1020)

Arguments For (Cont'd)

And other thousands of physicians are happily covered by OASI through positions in clinics, schools or in industrial practice. Indeed, I know several physicians who have taken minor positions solely for the purpose of securing coverage.

What does the record show in regard to the desire of physicians to be included? A poll taken by the Academy in 1955 showed 394 in favor of voluntary inclusion, 101 in favor of compulsory inclusion and only 39 against any inclusion. The Ohio State Medical Association poll in 1954 showed 2,459 in favor of voluntary inclusion and 2,441 against. An analysis of polls taken in 40 State Medical Societies published in the *JAMA,* 61:1162 (July 21, 1956) showed a majority of the membership in favor of voluntary inclusion in 30 of the 40 states reported. This appears to be conclusive evidence that the House of Delegates of the AMA is not representing the will of the majority of the membership in this matter.

There is not sufficient space to give a thorough analysis of the provisions of OASI here, but briefly the maximum yearly cost to self-employed is now $141.75. For this one would receive retirement disability and death benefits at a fraction of the cost of that obtainable through private insurance. For the young physician, survivors' benefits in event of death, for his widow and children under 18, would be a maximum of $200 a month. For the older married doctor, the retirement and disability income would amount to $162.80 monthly for life subject to restriction at age 65 but unrestricted at age 72.

The entire country has long since accepted OASI as a reasonable and essential part of our economy. Can 59 million people be wrong and the AMA right with regard to this? Is the individual doctor to have a say in this matter of importance to his personal finances or is this a question which the AMA should decide for him?

American Academy of General Practice Schedules Program on Infections

Six medical schools will send top speakers to the Second Annual Symposium on Infectious Diseases. The one-day symposium, jointly sponsored by the American Academy of General Practice, Kansas University Medical Center and Lederle Laboratories, will be held Friday, September 19, at Battenfeld Auditorium on the medical center campus, Kansas City, Kan.

Arguments Against (Cont'd)

sole right of cancellation belongs only to the "issuing company."

6. The assessment of $267.75 per year (after 1975) will begin as soon as the degree of Doctor of Medicine is received. This applies whether the individual is in active practice, in training, or in a salaried practice of medicine.

7. This assessment can be changed without notice by the "issuing company" and the increase in the "premium" is binding on every physician in the United States and there is no recourse.

PLAN NO. 2
PRIVATE INSURANCE PLAN

What are the benefits?

A. **Retirement**

1. There are no ifs, no qualifications, no exceptions. At the age of 65 he will receive an amount exactly as contracted for.

B. **Survivors**

1. There are no ifs, no qualifications, no exceptions;
   a. Benefits paid to widows, children as contracted for and specified in contract.
   b. An estate is developed. Someone receives the benefits accrued in accordance with the will of the insured.

C. **Disability Benefits.**

1. There are no ifs, no qualifications, no exceptions.

2. Benefits are paid in accordance with contract.

These benefits are guaranteed and cannot be cancelled by the issuing company as long as premiums are paid. The sole right of change belongs to the insured.

What does it cost?

1. The cost depends on the type of protection needed and desired.

2. The premium is fixed and cannot be changed by anyone while the contract is in force.

3. Participation is voluntary and its acceptance does not in any way bind any other physician in this state or any other state.

Plan No. 1 is not hypothetical, it is the plan offered by Social Security. The statements made are factual without any coloring matter added.

Plan No. 2 is private insurance.

It is inconceivable that any State in the Union would allow and license a private insurance carrier to offer for sale a policy such as outlined in Plan No. 1 with its ifs, ands and buts.

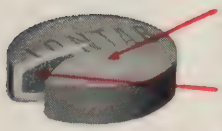
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relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.



Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

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SUPPLIED: Pyribenzamine *Lontabs* — full-strength — 100 mg. (light blue).

NOW AVAILABLE: Pyribenzamine *Lontabs* — half-strength — 50 mg. (light green) — for children over 5 and for adults who require less antiallergic medication.

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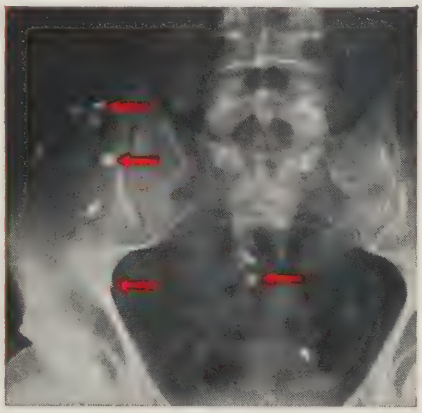
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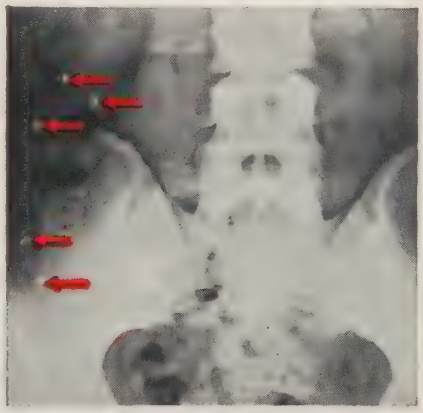
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.





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The Stoneman Press will still have the type standing on the August Ohio State Medical Journal until the *15th* of the month and will furnish reprints of your article at the following prices:

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

THERE IS NO VALID EXCUSE FOR STAYING OUT OF POLITICS

It could be that the fate of the private practice of medicine will be decided by the new Congress which will be elected on November 4 and which will take office in January, 1959.

What can be done about it? What can you do?

The answer's simple: **Get out and work for and elect candidates for Congress who are definitely against any and all socialistic proposals,** including those to extend the activities of the Federal Government into the area of health care . . . for example, the Forand Bill.

If you don't want to be told by us, then heed what a member of Congress, Hon. Ralph W. Gwinn, N. Y. has to say. Here's what Mr. Gwinn wrote in part to a businessman who asked for support for a certain bill to amend the Taft-Hartley Law in which business generally was interested:

"The trouble in Congress is not that we don't know what legislation is needed. We don't have the votes to get it passed. That should be obvious to anyone who knows anything about Washington, but business as a whole either does not know the facts or else refuses to face them.

"What can be done?

"Why do businessmen spend their time and money trying to sell their ideas to Members of Congress already committed or pledged against them?

"For example, what sense does it make for those who want a sound tax program to do nothing to elect sound Congressmen, and then spend millions to try and sell that tax program to a labor-socialist-dominated Congress?

"The horse is already stolen—the lock, the barn door, and the barn too, for that matter.

"If the businessmen of America won't see to it that men are elected committed to restoring constitutional government and law and order in labor-management relations, who else will?

"Business already has thousands of organizations at all levels of society that should have been doing this job. They are the only ones having adequate organizations. They avoid politics. If these organizations continue to rely on resolutions (as to what somebody else should do), 'educational programs,' publicity, going through the motions of lobbying, conventions, Washington representations of all sorts, letterwriting campaigns to the few remaining Members of Congress who agree with them, or to the many Members of Congress who never agree, we might as well resign ourselves to living under a labor government for a long time.

"Business organizations must stop looking for excuses to stay out of politics.

"How many businessmen know exactly how their present Congressmen vote? How many know their Congressman's name?

"It's up to you and others who think as you do to get to work in your congressional district now."

What Congressman Gwinn has said with regard to businessmen and political action applies equally as well to physicians and political action.

Are you preparing to do something between now and November 4 . . . and on November 4 at the polls?

To paraphrase what Mr. Gwinn so aptly said about business and businessmen: **The medical profession and physicians must stop looking for excuses to stay out of politics and must get out and work for those candidates who think as they do on major issues.**

SOUND VIEWPOINT TAKEN BY OHIO ATOMIC COORDINATOR

It's unfortunate that so few men in public office fail to have the vision and common sense expressed recently by William H. Eells, coordinator of Atomic Development Activities in Ohio. Here's what Eells said in an article on Ohio's 1957 atomic energy law, appearing in the magazine *State Government*:

"The Ohio law was patterned after the model bill proposed by the Council of State Governments and the New England Committee on Atomic Energy, but contained a number of changes and additions which were definitely an improvement, and have already proven the seriousness of purpose with which the sponsors considered this legislation.

"A number of the plans that have been brought forward throughout the country since the model bill are lacking in realism.

"As a political scientist with a practical approach, I personally believe that, when establishing any new role for government, you must face the poli-



running noses . . .



and other hay fever symptoms

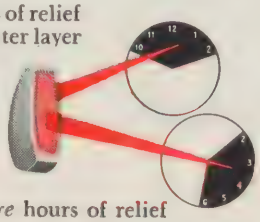
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action—systemically—with TRIAMINIC.

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tical facts of life. Until the states have had more time to try and evaluate this new role, there should be cooperation with and as little disruption to existing agencies and established lines of authority as possible.

"Although some of the states have first passed legislation dealing with only specific phases of atomic energy, such as the registration of all users of ionizing radiation, I believe Ohio's legislators were wise in establishing a general law setting up the basic machinery needed to look at the problem of future legislation as a whole, and to make a careful study as to actual and practical needs, before enacting new codes and laws.

"For the most part, where possible, future legislation should be based on substantiated and sound data, which in turn should be based on experience."

Physicians, especially those who are directly concerned with the use of radiation in the practice of medicine will, we are sure, say a loud "amen" to this sound statement by Ohio's atomic coordinator.

ETHICS AND THE EMPLOYED PHYSICIAN

Here's a Question which bobs up occasionally:

"Is it ethical for a physician to accept employment under another physician or in a clinic on a part-time basis?"

The Judicial Council of the AMA has this to say on this matter:

"It is not unethical in itself for a physician to accept part-time employment under another physician or in a clinic. The physician so employed and his employer must observe, however, all Principles of Medical Ethics in their relationship with each other and with their patients."

Although the Judicial Council did not in this ruling touch on the legal aspects, they must be taken into consideration. For example, should the employment be in a set-up which violates the Ohio law prohibiting the corporate practice of medicine, then all physicians involved in the set-up would be in jeopardy.

WHY AND HOW MALPRACTICE SUITS HAPPEN

Out in California where the medical profession has been literally plagued with malpractice threats and suits, the California Medical Society has done a lot of research on the causes—the reasons underlying suits.

The following comments from an analysis prepared by that society on why and how malpractice suits happen should serve as a warning to physicians—a preventive; so read them studiously:

"Malpractice suits don't 'just happen.' They have a history—a history that only rarely involves actual malpractice. Their origins almost always lie in the relationships between people, not just in the outward 'facts' of medical care.

"Malpractice suits start, flourish, and flower when patient and doctor do not understand each other—when each, in his own way, is unable to face realistically and directly the feelings that arise in the doctor-patient relationship during the treatment of illness.

"Even real medical mistakes seldom lead to suits if the doctor-patient relationship is based on mature understanding of what people and medicine can and cannot do.

"What makes patients likely to sue or doctors likely to be sued has very little to do with the patient's medical treatment or with the doctor's skill, training or competence.

"The attitudes that make doctors or patients 'suit-prone' are matters of the personality—emotional problems.

"The malpractice suit is a symptom of the breakdown in the doctor-patient relationship. It is a symptom that arises when disappointment and anger dominate. It is a symptom which usually means that both the doctor and the patient have attitudes, expectations and personal traits that make it hard for each to deal with the intense emotions that may arise in both: in the patient when he despairs of health or help; in the doctor when he senses the loss of the patient's admiration or his own self-respect."

NOW IS THE TIME TO BEAR DOWN ON RECORDS OF EXPENSES

That annual roundup of expenses vs. income, known as the income tax return, has probably caused many a physician to murmur, "Next time I'll keep better records of my expenses."

The Internal Revenue Service recently has been bearing down hard on expense accounts. Since a physician's expenses comprise a big percentage of his gross income, expense deductions mean more to him than they do to most taxpayers. Those dollars and fractions thereof paid to the parking lot attendant, the messenger boy and a hundred others count up to real money by the end of the year. Jot it down; keep charge accounts so you'll have a record; instruct your bookkeeper to keep needling you for an accounting.

You'll find the time consumed in keeping records will more than pay for itself when that income tax return rolls around again.

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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians: Developments in Medical and Health Fields

The problem of viruses that attack Army recruits in epidemic proportions while leaving seasoned veterans untouched has been solved with production of a counteractive vaccine. The viruses had produced a type of influenza uncommon in civilian populations.

* * *

Dr. Warren F. Draper, director of UMW Welfare and Retirement Fund, told American Labor Health Association convention in Washington that Fund never will return to free choice. AMA General Manager F. J. L. Blasingame countered with statement charging "medical interests of the miner and his family have been subordinated to the financial interests of the Fund."

* * *

Constituent units of National Institutes of Health are seeking patients with following diagnoses for admission to 500-bed NIH Clinical Center: Cancer Institute—Acute leukemia, Hodgkins disease without previous therapy, multiple basal skin cancer cells and others; Allergy and Infectious Diseases—Proved or strongly suspected cases of disseminated histoplasmosis; Heart—Patients with hormone-producing malignancies of adrenal gland. Letters of referral and histories may be sent to Director, NIH Clinical Center, Bethesda, Md.

* * *

Public Health Service has contracted with seven pharmaceutical houses for production of chemical agents for possible use against cancer.

* * *

Dr. Richard L. Meiling, former OSMA president and chairman of AMA Military Medical Affairs Committee, was spokesman for AMA opposition to move to down-grade Defense Department's assistant secretary (health and medical) to assistant to the secretary. Dr. Meiling stated in Washington that the AMA has "demonstrated an interest in assuring that the best available medical services are provided for our armed forces in time of war and peace."

* * *

Army plans to vaccinate all active duty personnel with polyvalent flu vaccine that protects against Asian, swine, A., A-prime and B strains.

Offices of Defense Mobilization and the Federal Civil Defense Administration now are merged into a single agency known as Office of Civilian and Defense Mobilization.

* * *

Atomic Energy Commission has set up national network to protect public in event of an accident involving radiation. Radiological teams of physicians, scientists and engineers, trained in safety techniques, would monitor radioactive materials and advise on hazards and control of them.

* * *

Secretary general of MEDICO (Medical International Cooperation), a unit of International Rescue Committee, reports that more U. S. physicians have volunteered for overseas missions than can be used. MEDICO hopes to raise $500,000 by public subscription to send six medical teams to Southeast Asia to set up clinics, according to the secretary-general, Dr. P. D. Comanduras.

* * *

Internal Revenue Services has liberalized interpretation on regulations relating to costs of schooling mentally retarded children and keeping them in institutions, now holding that full cost is deductible for child in an institution as a medical expense, and full cost of enrollment in special school, including meals and lodging, is deductible if child is enrolled for alleviation of mental or physical handicap.

* * *

Public Health Service has promoted to rank of assistant surgeon general Harry G. Hanson, who activated Robert A. Taft Sanitary Engineering Center in Cincinnati four years ago and has headed the center since then.

* * *

American Red Cross estimates it has provided $57 million worth of blood fractions to physicians throughout U. S. for use in therapy and research since 1944.

* * *

National Association of Broadcasters Television Code has been amended to ban portrayal of doctors, dentists or nurses in TV advertising by other than members of those professions. Code is subscribed to by 308 stations and the three networks.



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You and Your Public . . .

Community Service Awards to Three Ohio Physicians Reflect High Honor on Them and Their Profession

WITHIN a 10-day period recently three Ohio physicians in three different communities were presented distinguished service awards by their fellow citizens.

Contrary to what some pollsters, surveys and self-appointed sages would have the public believe, the medical profession continues and will continue to enjoy high esteem. This is borne out by these awards, which mean good public relations for these three doctors and their profession.

Honors Deserved

These physicians didn't just happen to be selected for honors. Their honors came as the result of continued interest in and service to their communities.

In Middlefield, Dr. Hubert Shafer was honored as "Man of the Year" by the local Chamber of Commerce for his 31 years of service to his community.

In Bellefontaine, Dr. A. J. McCracken was presented with the Bellefontaine Kiwanis Club's Distinguished Service Award. Dr. McCracken enjoys a long history of community service.

In Garfield Heights, Dr. Charles Blaugrund was named "Man of the Year" by John R. Lawrence Post 304, American Legion. This recognition also resulted from a record of outstanding civic service on the part of Dr. Blaugrund.

It should be noted that these physicians achieved such recognition for their contributions primarily to the medical life of their communities, in addition to contributing to other aspects of community life. It is good public relations for the physician to give his best professional interest and service to his community.

Not Done Just For PR

This is not meant to say that such should be done only for the sake of public relations. It should be done for the sake of good medicine, and the result is worthwhile PR. Public Relations is not press agentry. Public relations has been defined by experts in the field as "doing a job well, and getting credit for it." It is not something artificial.

Thus, these physicians have been "doing a job well" and their fellow citizens have seen that they got credit for it. There is nothing artificial about their accomplishments.

This presents medicine and the medical man in the best possible light. It is far more penetrating, productive and lasting than a mass approach to medicine's PR problems.

American Association of Medical Assistants Meeting Announced

Plans have been made for the Second Annual Convention of the American Association of Medical Assistants at the Palmer House, Chicago, October 31, November 1 and 2.

The American Association of Medical Assistants is made up of those employed as assistants in the offices of doctors of medicine. The Association was conceived in Kansas City, Kansas, during the fall of 1955 when interested persons from 15 states met to make plans for a formal organization. The second meeting was held the following year in Milwaukee, Wisconsin, at which time a Constitution and Bylaws were adopted and the Association formally set up. During this first official year, a great deal of work was done and the First Annual Convention was held in San Francisco, California, in October, 1957. Now, it has a membership of nearly 6,000 representing 17 states and has the approval of the American Medical Association. The Ohio Society of Medical Assistants was approved recently by the Ohio State Medical Association's Council.

The purposes of the Association are stated as follows: To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve; to strive at all times to cooperate with the medical profession in improving public relations; to render educational services for the self-improvement of its members; to stimulate a feeling of fellowship and cooperation among the societies.

Several states now offer fine educational courses with the cooperation of their colleges and universities which will help the assistant to become more valuable in the doctor's office. The American Association plans to offer courses on a national level as soon as a suitable curriculum has been set up.

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—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

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THE JOURNAL
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Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

"Widescreen medical public relations" focusing on a broader segment of national life will be considered when key medical men meet in Chicago August 27 and 28 for AMA's 1958 PR Institute. The 1958 session at the Drake Hotel, billed as the "V.I.P. Meeting," is designed for physicians, medical society staff personnel and others working in the medical public relations field. The keys to the medical profession's public relations program in the year ahead are symbolized in the meeting title and will be revealed at the day-and-a-half-long session.

The workshop-styled program will get down to PR practicalities at its opening session with a discussion of medicine in a changing world. From the lead-off "what do you know?" session the meeting will move into deliberations on "what have you got to say?" "how do you say it?" "whom do you know?" and "are they listening?"

Top people in related fields, including communications and human relations, will take part in the program.

Report on Hill-Burton

Results of a two-year study of the Hill-Burton Hospital Survey and Construction Program will be available in booklet form soon from the Committee on Medical and Related Facilities of the AMA's Council on Medical Service. Sections included in the report—introduction; summary; conclusions; recommendations; federal grants-in-aid; background and basic administration; general hospitals; tuberculosis hospitals; public health centers; mental, chronic disease and nursing home facilities; diagnostic or treatment centers; rehabilitation facilities, and other reference material. In addition to reviewing the legislative background of the Act and a voluminous amount of other data, reports on field surveys made in the following states are included: Arkansas, California, Connecticut, Georgia, Illinois, Iowa, Kentucky, Maryland, Michigan, Mississippi, Montana, New Jersey, Oregon and Washington. A limited number of copies will be available to individual physicians and medical societies.

Nursing Home Study

A field survey of approximately 25 skilled nursing homes in various sections of the country is being conducted this summer by the AMA's Council on Medical Service. Primary purpose of visits to these public, proprietary and non-profit facilities will be to obtain data that will aid in developing recommended guides and standards governing medical care in nursing homes. It is expected that much valuable information will be gathered on other important phases of nursing home operation —including nursing care, social service, food service, staffing and personnel policies, and costs. Tentative plans call for publishing the results of the survey, along with suggested standards for medical care and supervision, this fall.

This field study is one of the activities which has grown out of meetings of the liaison committee of the American Medical Association and the American Nursing Home Association. Other problems currently under the committee's consideration are the adequacy of welfare payments for nursing home care, ways of financing new and improved nursing home facilities, and stimulation of a better working relationship between nursing homes and physicians at both the state and local levels.

New Film on Food Quackery

How modern "medicine men" dupe the public into spending millions of dollars on unnecessary or over-priced nutritional products is the story unfolded in a new American Medical Association film. Prepared especially for airing over local television stations under the auspices of local medical societies, this new 27-minute film—"The Medicine Man"—dramatically pinpoints the fight against quackery in the food and nutrition field.

The film singles out problems which stem from health lecturers who travel from town to town giving misinformation on nutrition as a tie-in to plugging their products of questionable merit and from door-to-door salesmen who misrepresent the value of nutritional products. The film also shows how the medical profession cooperates with the Food and Drug Administration and voluntary agencies such as the National Better Business Bureau in the crackdown on these food quacks.

First showing of the film will be at the AMA's Public Relations Institute August 27-28 at the Drake Hotel, Chicago. Prints will be available to local medical societies after September 15 from the AMA TV Film Library.



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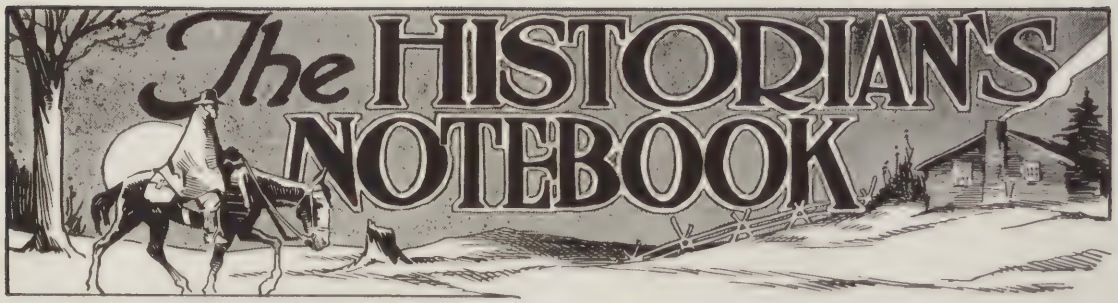
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What of the Day, Sir?

MARTIN FISCHER, M. D.

HUNGER, pestilence, war and death remain the feared figures in the drama of mankind, and every generation has tried in its own way to mitigate the harshness of these monsters, both materially and spiritually. Success has varied.

Reliable geographic analysts inform us that 80 per cent of the world's peoples stand chronically on the verge of starvation—due either to lack of quantity or of quality of food. We remain entangled in the laws of Malthus, who a century and a half ago pointed out that as food supply doubles, population number, trebles. Because for us this situation lies far in the future, and because faithful missionaries have carried our surpluses to every needy portion of the globe, we incline to forget it all and to do nothing adequate to stop an ascending spiral.

The hopefuls believe that having struggled out of some short-lived disasters, we will always be able so to do. But is that true? It brings up the difficult chapter of raising more food and/or of engaging in birth control. New lands will be found and better fertilizers will be discovered (or be produced artificially) but, obviously, these schemes will only ameliorate, not abolish, an economico-biological law. (And the Government will be of little help when at the same time it subsidizes the one farmer for keeping land out of production, even as it subsidizes a second for bringing arid lands in.)

Why More People?

Any discussion, even, of birth control arouses violent objection. The military has always been for more soldiers; the farmer desires sons to continue the farm; and the industrialist likes large pools of workers—both male and female. Until recently the wardens of our morality have rid themselves of the load by labelling the whole idea of family limitation, sin.

What now gives concern in school, court and playground is not only the numerical increase but the inequality of the starting material. As everybody knows, men are not born equal, and to be good for society it is the better-endowed—morally, mentally and physically—that we would have decorate our stage. We prate much about how these inborn inequalities may be corrected toward better side.

The Communistic Approach

One group holds that the distribution of food and of goods is poor; and that with proper consideration of the environment in which man lives, all might be fed both in their bodies and in their souls. But the history of new-dealism, socialism and communism does not in practice support these philosophies. Recall that colonies, like those of Jamestown and Plymouth, all failed as long as they lived together on a communistic basis. Not until the Plymouth Colony had returned to a free enterprise system—and that was three years after their landing—was there enough overproduction to permit the inauguration of a day of feasting and thanksgiving. After these, consider the economic tragedy of Friendship in Maine, of Robert Owen's community in Indiana, of Ohio's settlement in Lebanon, of Kentucky's Shakertown

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Read before The Literary Club, Cincinnati, Ohio, January 27, 1958.

below Lexington. It took a little longer for them to die, but die they did!

The Medical Approach

Better progress toward the longer and happier life is registered in the increasing conquest of pestilence. It took only a half century to increase man's life span in the United States from less than 50 years to over 70. Compare this with the twenty-odd years of life allotted to the Asians and the southern-lying hemispheres. U. S. A.'s feat was accomplished by a better appreciation of what are the sciences of agriculture and animal husbandry, aided and abetted by the great advances in bacteriology and hygiene.

The middle thirties of this century brought glad hosannas when it was found that, employed early, the sulfonamides and the antibiotics could forestall many a major operation. The latter cut down enormously, morbidity; and in best case, cut it out. This is because most disease is a battle between a parasite and a host; and the modern drugs turn the tide in man's favor. An earache was not so often followed by a purulent mastoid bone; not every appendix exploded; and not every abscessing Fallopian tube called for excision. The last item was important because in this surgery, excision of the ovary, too, was often required. The modern drugs saved the woman a spaying—and all its bitter emotional aftereffects.

And now about another hush-hush story!

The Biologics of Sin

The modern radio songstress bids you "take a chance!" Employed in a business sense, this might refer to the romance of business risk. But more sentimentally viewed, it refers to the romance of "the night before." Regarding it, one school of thinkers would escape the discomforts of brain work by simply ignoring the question of sex. But that is not easy, for sex is one of the only three instincts by which all life maintains itself. As of now and in the future, dalliance will be a less romantic but a safer affair. It will allow sin to grow because its accompanying dangers are being increasingly eliminated. And how? By the simple trick of soaking the principals concerned, prophylactically in the antibiotics. Thus will chemistry make meaningless the dogma that the sins of the fathers will be visited upon the children.

Confusion

Like the rest of the world, the war situation and the desire of man to be free befuddle me. A cartoon by Alan Dunn in a recent *New Yorker* (July 27, 1957) gives me solace. Two construction workers, 10 stories above the street level, are guiding an "I" beam into place. One speaks to the other: "I figure, what's it matter? If cigarettes don't get you, the fall-out will!" For the truth, keep listening.

Some years ago I ventured the opinion that there would never be a third world war in which gas would be employed. It was for a very simple reason—military victory has become as destructive of the conqueror as it is of the other fellow. Fight continues, as Lord Russell has phrased it, only as long as you believe that your enemy is suffering more than you. To rule a land requires occupation, and ground poisoned for the conquered, is poisoned for the invader also.

Substitute in the arms race, the atomic missile for poison gas, and you have the situation as of today, the facts of which are only slowly coming in. The public has thus been permitted to observe that the first atomic bomb was dropped on Hiroshima on August 6, 1945. Out of a population (in round numbers) of 344,000, the dead were 78,000, the injured 37,000 and the missing 13,000. The casualties, in other words, were one third of the population. When a second bomb was dropped on Nagasaki, similar figures appeared. Out of Nagasaki's population of 250,000, the dead alone were 73,000—again nearly one-third!

Ways to Death Compared

But this recitation does not tell the complete story. It is not these immediate effects of the bomb that need trouble you, but the remote. Shock and light only tear to bits and burn and fry you if within a radius of several miles; it is the fall-out that writes a story that is forever.

In simplest terms it is the x-ray-like emissions that sooner or later maim and kill; and in a most ugly manner.

The radiations from an atomic bomb are more and denser than those of the x-ray tubes employed in medicine. But in nowise are they different. In fact, clinical experience has been a sort of laboratory for the testing of radiation effects. It has become common knowledge that the x-ray specialists live five years less than the professional average, and that in the years of their work they develop anemias, leukemias and cancer. As for the overdosed patient, so for the victim of the atomic bomb—his state is the same but intensified.

There occurs in the acute case what is called radiation sickness and the stricken may in weeks vomit himself to death. But it may be a decade or two before the aftereffects manifest themselves—

and most subtly. The fine mechanisms of cellular growth are disturbed, distortion results and a "mutant" of questionable value is born.

Where Are You Going?

Now just a line on what Civil Defense may accomplish. The answer is, *nothing!* As the genius-builder of the highways and the parkways of New York, Robert Moses, has pointed out, the entire plan of creating a civil defense to duplicate what we already have in the Government, has proved a fiasco. The already overcrowded roads will not widen for a fleeing multitude, and those on the run will not know in which direction to go.

Some months ago, a colleague of mine passed the signboard before a public school. It read: "In case of attack, use this building as a shelter." He took some chalk from his pocket and relettered the sign: "In case of attack, this shelter won't be here."

But if there is no refuge upon the earth, neither is there one below, for the very design of a bomb cellar to avoid disaster is one that will better invite it. The ventilating system called for, will only bring the atomic dust of the atmosphere more quickly into the shelter, to create a situation that will come about anyway. Can nothing be done? The plan of a patient of mine is good. She is going to seek out a corner in the region in which she may be, and pray.

When is Life Long?

The fourth rider of the Apocalypse is death. Can it be outwitted, and for how long?

In the centuries gone, man has established himself as the ruler of the earth. He has accomplished this because he has multiplied and because with time he has learned the better way in which to down his enemies beginning with those of the beasts of the field and ending with the viruses. Thus he has more and more deferred the hour of his death. Instead of needing to meet death in his twenties, he could with better knowledge, wait into his forties.

But man did not stop there. Today he can sit secure (in U. S. A.) into his seventies. Will he endure to his biologically calculated age at death of 140? Nothing stands against that possibility, wherefore it may be asked how long *can* he live, or in reverse, why death at all?

Up to a short time ago, the oldest living thing in our world was the redwood of California. It was calculated that it and the Christian Era got started at about the same time. But now the botanists have come forward with a new finding—that of a Pacific Coast pine at least 3,000 to 5,000 years old!

Just how long is eternity?

Of Historical Interest

From the Closed World to the Infinite Universe, by Alexandre Koyre. ($5.00, *Johns Hopkins Press, Baltimore 18, Md.)* This is one of the Hideyo Noguchi Lectures in which this famous historian of science charts the path beginning with the philosophy and science of the Middle Ages and changes in thinking and appreciation of the 16th and 17th centuries which changed things into the world of the modern with its concept of an infinite universe and devoid of all hierarchial structure. It begins with Nicholas of Cusa, goes on to the works of Copernicus, Bruno, Kepler, Descartes, Newton, and Leibniz and the other thinkers of the period. Particular attention is given to the 17th century discussion between Descartes and Henry More and to the world view of Newton. Several chapters deal with the problems of the origin of the Newtonian conceptions and the reaction of Newton's contemporaries, such as Berkly, Raphson and Leibniz. Throughout the book the author keeps close connection between the development of scientific and philosophical thoughts and their interreactions.

The Road to Inner Freedom: The Ethics, by Baruch Spinoza. ($3.00, *Philosophical Library, New York 16, N. Y.)* Edited and with Introduction by D. D. Runes. **Ethics,** by Spinoza, is well known to professional philosophers. However, it has never received the wide reading that it deserves. For this the editor offers a very simple reason. Although dealing with the problems of man's emotional and intellectual life in direct and forthright terms, Spinoza saw fit to couch his ideas in mathematical formulations and scholastic terminology. Because of danger to himself and family because of religionists he never dared print the text during his lifetime but the book was circulated widely in manuscript form. It became familiar to most of the intellectual leaders in western Europe in the 17th century. Even this limited circulation brought the author into conflict not only with the Jewish religious bodies of Amsterdam but with the representatives of the various Christian churches.

The Cultural Life of the American Colonies, by Louis B. Wright. ($5.00. *Harper and Brothers, New York 16, N. Y.)* It covers the period from 1607 to 1763. Since it reports on the cultural interest and achievement of our Colonial ancestors, in terms of their opportunity, their social status, their national origins and geography, it fills a very useful niche in the library of those of us who are interested in the background of American scientific knowledge.

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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 54 August, 1958 No. 8

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Survival Following Rupture of an Arteriosclerotic Abdominal Aortic Aneurysm (Report of a Case)

JACK E. TETIRICK, M. D.

RUPTURE of an abdominal arteriosclerotic aortic aneurysm need not lead to immediate death from exsanguinating hemorrhage. Appreciation of the fact that there is usually a period of time in which typical symptoms may be recognized prior to the final episode of rupture into the free peritoneal cavity or into a viscus can yield an appreciable salvage of such patients. Even after the rupture into the free peritoneal cavity has occurred there can be opportunity for survival providing immediate surgical therapy is instituted.

The surgical undertaking is one of precision and magnitude in terms of facilities, personnel, and the care of expected complications. In view of an increasing distribution of the facilities for aortic replacement, a careful chronologic description of an actual incident may help those who desire to be prepared to meet this urgent surgical emergency.

Case Report

History of the Present Illness. Mr. — was admitted for the first time to the Emergency Ward of the Massachusetts General Hospital on June 13, 1956. The patient was a 72 year old watchman who complained of abdominal pain and vomiting of two days' duration. For approximately one year he had been complaining of vague abdominal pain described as a "bloating feeling" associated with moderate anorexia. During the four to five weeks prior to admission the patient had felt that there was an objective and subjective increase in the size of his abdomen.

Two days prior to admission, while at work, he was seized with a severe pain which was described as being predominately in the right upper quadrant of his abdomen, and radiating occasinoally to the right lower chest. About one hour after the pain commenced, the patient vomited for the first time and thereafter was unable to retain any food up to the time of admission. About one hour before being admitted to the Emergency Ward he was reported to have been unresponsive, cold, and clammy. It was stated that just prior to his admission he had passed three small black stools. The patient denied any hematemesis or melena other than the above history. He denied any recent change in bowel habits. The patient stated that he had lost approximately 45 pounds in the year prior to admission.

Family History. Noncontributory.

Social History. Noncontributory. He smokes two to three cigars per day. Alcoholic intake was denied.

System Review. The only pertinent finding by system review was the finding of a chronic cough of many years' duration.

Physical Examination

Physical examination showed a thin, pale, chronically ill male who appeared to be of his

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stated age. A somewhat uriniferous odor was noted to his breath. The blood pressure was 88/50. Pulse 90. Respirations 16. Temperature 98°.

Skin and Lymph Nodes. Negative.

EENT. Examination of the eye ground showed 2 to 3 plus arteriosclerotic changes with some arteriovenous nicking, otherwise this portion of the examination was negative.

Heart and Lungs. Examination of the lungs by percussion revealed bilateral dullness in the bases posteriorly and by auscultation there was diminished breath sounds and fine to medium rales extending one third of the way upward from the base. The heart was enlarged to three centimeters beyond the left mid-clavicular line. There was a grade 2 basal systolic murmur. This murmur was widely transmitted. The cardiac rhythm was regular.

Abdomen. Examination of the abdomen revealed it to be protuberant and distended with dullness posteriorly in the flanks and tympany anteriorly. There was no shifting dullness or definite fluid wave. The abdomen was too tense to feel any organs or masses. The genitalia were normal.

Rectal. Rectal examination showed an enlarged prostate gland which was smooth and symmetrical.

Extremities. Examination of the extremities showed bilateral posterior tibial pulsations. There was no clubbing or edema.

Neurological Examination. Noncontributory.

Laboratory Data

On admission the patient had an hematocrit of 21 per cent. The hemoglobin was 5.8 Gm. per 100 ml. The white blood cell count was 11,150. The differential was as follows: polymorphonuclear leukocytes 81, lymphocytes 17, monocytes 2. The red blood cell morphology showed hypochromic cells with a moderate anisocytosis and microcytosis. The reticulocyte count was .2 per cent. A bone marrow study was reported as entirely normal. The platelets were normal in number and appearance. The serum sodium was 132 mEq./l, the serum potassium 3.9 mEq./l, the serum chloride 96 mEq./l, the CO_2 was 29 mEq./l; the blood *p*H was 7.45, the nonprotein nitrogen 62 mg. per 100 ml; creatine was 2.74 mg., and the serum water was 279 milliosmols/l; the serum iron was 70 micrograms (normal 50-200). Three guaiac determinations were done on the stool for occult blood and all were negative. A blood Hinton test was negative.

An electrocradiogram showed normal sinus rhythm and was considered normal except for several minor T wave abnormalities. An x-ray film of the chest showed some atelectasis of the left lower lobe. An x-ray film of the abdomen showed moderate gas and fecal material scattered throughout the colon. There were some irregularly shaped calcifications arranged roughly in the form of an arc just to the right side of the second and third lumbar vertebrae and they were thought likely to lie in the wall of an aortic aneurysm.

The cardiac compensation was thought to be borderline with a venous pressure of 175 mm. of saline and a circulation time of 20 seconds.

Hospital Course

For the first two days of the hospitalization the patient continued to complain of moderate abdominal pain and it was during this time that most of the foregoing laboratory and diagnostic data were obtained. On the afternoon of the third hospital day, while visiting with relatives, the patient suddenly became unresponsive and went into profound shock with an unobtainable blood pressure and pulse. The abdomen immediately became very tender and all bowel sounds disappeared.

At that time he was seen in consultation by the author at the request of the medical service. The opinion expressed at that time was that the history was most consistent with a neoplasm of the colon which had perforated. Note was made of the fleck of calcium on the abdominal film and it was suggested that an aneurysm which had ruptured was a definite diagnostic possibility. Early exploration was recommended and accepted by the patient's physician and family. Immediate massive blood replacement was begun and the patient was transferred to the operating room.

Operative Report

Preoperative diagnosis: Perforated carcinoma of the colon. *Postoperative diagnosis:* Ruptured aortic aneurysm. *Name of procedure:* Resection of abdominal aortic aneurysm with homograft.

Under satisfactory nitrous oxide-anectine-cyclopropane anesthesia, the patient was placed on the operating table in a supine position. The abdomen was prepared with soap, alcohol, and Zephiran® solutions. Sterile drapes were applied and the abdomen was entered through a long left perimedian incision. Upon opening the abdomen, fresh arterial blood was encountered in profuse quantities; the small bowel mesentery was filled with clots and there was a huge retroperitoneal hematoma. Therefore, the incision was extended upward and downward until it ran from the pubis to the costal arch.

Control of the aorta superiorly was secured by

passing a shoe string behind it and attaching this to an occlusive clamp which was the Linton modification of a Bethune lung tourniquet. This clamp was then closed so as to occlude the aorta above the renal arteries and thereafter the clot was rapidly extracted and the aneurysm exposed. Bulldog clamps were placed across the iliac vessels. The aneurysm was then resected on the free surface, but a portion of the aneurysm wall was left in situ on the caval and posterior side. When the upper end of the aneurysm had been dissected and divided, the proximal end of the aorta below the renal vessels was controlled with a Crafoord clamp and the Bethune tourniquet was released allowing perfusion of the kidneys with arterial blood. The period of absolute renal ischemia was 27 minutes.

Following this, an aortic frozen-irradiated homograft was placed in the defect. An en-to-end suture technique was used at the upper end utilizing a vertical mattress suture of 5-0 arterial silk. On the anterior portion of the graft it was necessary to make a small vertical incision in order to enlarge the orifice of the graft to make it more nearly correspond to the aortic lumen of the host. On the inferior end, an end-to-side technique was used to anastomose the graft to the common iliac vessels. There was good retrograde blood flow when these vessels were opened. The ends of the vessels were sutured using an over and over suture of 5-0 arterial silk.

After the left anastomosis had been completed the clamps were removed and the blood was allowed to flow through the graft and down the left leg. The suture lines were hemostatic. The right anastomosis was made and the clamp was taken off the limb of the graft following which more adequate hemostasis was secured. As much clot was then removed from the retroperitoneal area as possible and the parietal peritoneum was closed to the small bowel mesentery in the region of the dissection with a running 2-0 chromic catgut suture.

The anterior peritoneum was then closed using a running suture of 0 chromic catgut. Through and through wire sutures were placed through the external rectus fascia. The fascia itself was closed with interrupted sutures of 3-0 silk. The through and through sutures were tied and the skin was closed with interrupted sutures of 5-0 silk. Upon completion of the procedure the patient had received 13 blood transfusions. There were palpable bilateral dorsalis pedis pulses. The patient's condition was recorded as fair.

Postoperative Course. The postoperative course was stormy. He developed a profound ileus and had considerable difficulty with tracheobronchial secretions. On the second postoperative day a tracheostomy was performed. The urine output remained low and on the fifth postoperative day the patient was noted to be jaundiced. The jaundice was thought to be the result of an incompatible blood transfusion although no gross reaction with any of his 21 transfusions had been noted (4 preoperative transfusions, 13 operative transfusions, and 4 postoperative transfusions).

Although his urine output remained low the patient's nonprotein nitrogen remained in the range of 45 mg. The study of the electrolytes and other blood chemistries revealed only a moderately elevated carbon dioxide content. This elevation was thought to be related to his respiratory problem, and following the tracheostomy and clearing of the pulmonary sepsis the CO_2 content returned to levels approaching 30 mEq./l. An arterial oxygen saturation was performed on the fifth postoperative day and showed 81 per cent saturation.

The patient was disoriented postoperatively and very difficult to manage, but this gradually cleared and by the twelfth day his respiratory difficulty had subsided sufficiently to remove the tracheostomy tube. The jaundice lasted for two weeks. It reached a peak bilirubin of 7 mg. per 100 ml., and by the thirteenth postoperative day had dropped to 2 mg. After the jaundice, respiratory sepsis, and oliguria had cleared, the patient became well oriented, very active and alert, and resumed his former interest in baseball and life in general. All pulses remained palpable in the extremities. He was discharged to be followed in the outpatient department on the sixteenth postoperative day.

Follow-up Data. The patient was seen in the surgical outpatient clinic one month after the procedure and was found to be without symptoms. The incision was well healed. Two months postoperatively the patient returned to work and was completely asymptomatic. A follow-up letter was received from him on June 3, 1957 (one year following surgery) and is here quoted:

"Dear Sir:

"I have had no symptoms, complications or diseases since I was operated on last June 14. I have increased my weight from 104 pounds to 126 pounds.

"My present condition is satisfactory and I feel real good.

"Sincerely,

"_____"

Discussion

Diagnostic Considerations. The sudden onset of abdominal symptoms in an elderly individual is likely to be due to a complication of vascular disease. When acute abdominal distress in such a

patient is accompanied by anemia and episodes of hypotension in the absence of melena, the diagnosis of a ruptured abdominal aortic aneurysm should be considered as a leading possibility. Indeed, any elderly patient with vague and recurring abdominal pain should be considered for this diagnosis. Although the reports on this condition in the literature state that a pulsating abdominal mass is usually present, the exact status of the abdomen is very difficult to assess and it is unwise to attempt to delineate a mass by vigorous palpation or discard the diagnosis because such a mass is not present.[1,2,3.]

The presence of serious associated disease processes should not delay the decision to undertake an attempt of surgical correction of the lesion beyond the time needed to evaluate these processes for reference in the postoperative period.

Technical Considerations. A discussion of surgical technique is beyond the scope of this report. Several remarks, however, are pertinent to the problem of facing "profuse quantities of fresh arterial blood upon entering the abdomen." Application of direct pressure blindly among the coils of the bowel must be avoided as this will only serve to waste time and enlarge the aortic defect. The most rapid hemostasis is secured by direct aortic occlusion.

The surgeon should slide his hand up onto the liver and down on its ventral surface to the aorta just below the diaphragm. When the aorta has been reached in this area it is possible to insert the index finger behind it by direct blunt dissection thereby producing occlusion between the thumb and forefinger. The peritoneal incision and subsequent control of the iliac vessels is then performed by the surgical assistant. The aneurysm is then opened lengthwise to allow rapid evacuation of the clots and control of lumbar branches. The standard techniques for this surgery are then applicable.

Postoperative Care. The presence of a large amount of retroperitoneal blood and the stress of an episode of shock and a major surgical procedure frequently have a transient but severe effect on the mental status of an elderly patient. Disorientation and confusion may be expected. It is therefore mandatory that continuous observation of the patient be carried out by the nursing and resident staff to prevent the patient from harming himself, or interfering with the drainage tubes and other equipment.

The Levine tube should be left in the patient for five days. This will help avoid ileus with consequent respiratory and wound complications. It is not unusual to see ileus develop if the tube is removed early even though a moderate amount of peristalsis has returned by the third postoperative day.

The pulmonary reserve is limited in most of these patients due to age, pulmonary disease, high diaphragms, and a long painful abdominal incision. Useful measures include the use of high concentrations of oxygen, early tracheostomy, and by refusing to allow the patient to be restrained flat in bed for reasons of his mental status.

The precarious condition of renal function is best aided by rapid surgery with reduction to an absolute minimum of time during which the aorta is occluded above the renal arteries. In addition, the total operating time should be as short as possible. In this respect it is mandatory that the assistants to the surgeon and all categories of operating room personnel be well versed in the techniques of vascular surgery and that a second surgical team prepare the substitute vessel while the resection of the diseased segment is being performed. Further protection is afforded to the kidneys by adequate blood replacement, and it is essential that several units of blood be given rapidly as soon as the aortic occlusion is released with a return of flow to one or both lower extremities.

Summary and Conclusion

A case of an abdominal aortic aneurysm complicated by acute rupture is presented. Diagnostic and therapeutic principles are discussed.

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Adduction. The patient was contacted on July 10, 1958, and stated at that time he was asymptomatic and had had no difficulty with his legs or abdomen since his operation.

Permanently Incapacitating Knee Injuries

Ligamentous injuries to the knee are among the most common of the permanently incapacitating injuries received in football. The most often injured is the medial collateral and less often the cruciates and the lateral collateral. I have used the word *permanent* with regard to such incapacity because it is my belief that after repair of a collateral ligament the knee cannot endure the trauma one must expect in football.—James J. Daly, M. D., San Francisco: *California Med.*, 88:441, June, 1958.

Supine Hypotensive Syndrome in Pregnancy; (Report of a Case)

KEITH R. BRANDEBERRY, M. D.

THE sudden onset of hypotension during late pregnancy or during labor ordinarily suggests the occurrence of some severe and perhaps catastrophic complication. Prompt, and sometimes dramatic action is usually necessary to preserve the lives of the mother and the fetus. Nonetheless, acute hypotension occurring during these stages of pregnancy may be due to some benign disorder that does not demand such vigorous intervention. An example of such a disorder is presented in the following case report.

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Case Report

Mrs. — was a 24 year old white primipara who entered Holzer Hospital on October 14, 1957, in early active labor. She had been followed through an uneventful prenatal course at this hospital. Her estimated date of confinement had been October 9, 1957. Her weight gain had been 29 pounds and blood pressure had ranged between 118/72 to 130/76. Urines were constantly negative. Laboratory work showed her to be Type A, Rh positive, hemoglobin 12.8 Gm., with a hematocrit of 41 per cent. The serologic test for syphilis was negative. Her only medication had been nutritive capsules, 1 three times daily. Her pelvic measurements had been noted to be small with the external conjugate 16 cm., the ischial spines 7.5 cm., and the true conjugate 11 cm. It was elected that she should have a trial of labor.

Upon admission at 6 p.m. October 14, her blood pressure was 122/82. She was having good contractions every four to five minutes. The cervix was 3 cm. dilated with membranes ruptured, vertex at minus 2 station. Throughout the night her contractions remained good and the cervix dilated to 9 cm. by 8 a.m., but without further descent of the vertex. Because of her failure to progress, it was elected to do a cesarean section. The patient was given Demerol®, 50 mg. and atropine, gr. 1/150 and sent to the operating room.

She was allowed to remain on the carrier outside the operating room in supine position for approximately 10 minutes, then moved onto the operating table. At this time, the anesthetists noted her blood pressure to be 30/0. The patient complained of feeling weak, but was not perspiring. Her pulse was barely perceptible. Meticulous examination, with the thought of a ruptured uterus, was negative except for the pulse and blood pressure noted. At this point, the patient was turned on her left side and within 20 seconds her pulse was good and the blood pressure was 112/64.

She was then turned back to supine position and the pressure again became imperceptible. Upon returning the patient to her left side, the blood pressure was restored to normal levels. The abdomen was prepared with patient in this position and Sodium Pentothal® anesthesia induced. She was then quickly turned to supine position and usual laparotrachelotomy performed. This removal of the baby required approximately four minutes, and during the interval, the blood pressure again fell to unobtainable levels. As soon as the uterus was emptied, the pressure returned to normal and remained so.

The postpartum course was uneventful and the patient and her infant (weighing 7 pounds 7 ounces) were discharged on her sixth postoperative day.

Other Reported Cases

In 1951, McRoberts[1] first described this rather uncommon and interesting condition and presented six illustrative cases. He suggested that "in late pregnancy the uterus may obstruct the veins of the abdomen when the subject is in the strictly supine position, causing a rise in venous pressure caudally and a fall in pressure in the right auricle." De Regende[2] felt, "that the syndrome is dependent on a reflex produced by the stimulation of the nervous structures situated behind the uterus."

Howard, et al[3], reported two cases, one of which was subjected to cesarean section because of a suspected ruptured uterus. They felt that the condition was not clinically recognizable in labor because "during a labor contraction the uterus apparently 'rides' on the vertebral column and cannot exert pressure posteriorly on either side

of the bony ridge." They were able to produce an acute hypotension in a near term bitch by ligation of the inferior vena cava below the level of the renal veins.

Conclusions

A case of Supine Hypotensive Syndrome during labor is reported. Our first thought, as has been the experience of others, was that of a ruptured uterus. By turning the patient on her side and observing the blood pressure rise, the proper diagnosis can be made promptly. This syndrome must be considered in any case of unexplained shock in late pregnancy. The ease with which the blood pressure could be made to rise or fall in the presently presented case suggests that McRobert's explanation of this phenomenon is the more accurate.

Biblography

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Occurrence of Cross-Sensitization Between Related Compounds

A subject which requires some mention is that of cross - sensitization, or multiple sensitivities. These are not necessarily the same thing. Cross-sensitivity occurs between chemically related compounds such as paraphenylamine diamine, para-amino benzoic acid, para-amino salicylic acid, benzocaine, nupercaine and the sulfonamides.

Allergic sensitivity to one of these drugs may produce an allergic reaction on exposure to a second one of the group, without prior specific exposure to the second chemical, occurring before the eliciting exposure. It is true that people who form allergic reactions and have the capacity to do so may become allergic to more than one substance without the presence of true cross-sensitivity. This occurs not infrequently for the metals nickel and chrome. Oftentimes a person sensitive to nickel will also be sensitive to chrome.

Cross-sensitization occurs between poison ivy, poison oak, poison sumac, Japanese lacquer, mango and cashew nut shell oil. Cross-sensitization occurs between the oleo resins of the iris, from which the insecticide Pyrethreum is prepared, also ragweed and chrysanthemum. Tetramethyl thio-urium disulfide, the germicidal agent in a new soap, may cross-react with the thio-urium compounds present as antioxidents in some of the rubber articles, including some rubber gloves.—Charles W. Whitmore, M. D., Lynchburg, Va.: *West Virginia M. J.*, 54:238, July, 1958.

Fluro-Ethyl Cryotherapy

An Adjuvant in the Treatment of Acne Vulgaris and Postacne Scarring

By *Irving L. Schonberg, M. D.*,* and *Jerome Z. Litt, M. D.**

The use of refrigerants in the treatment of postacne scarring is well known, and, in a recent report,[1,2] J. M. Greenhouse discussed the use of liquid nitrogen in the treatment of facial scars. We have used liquid nitrogen in 56 cases of postacne scarring with very satisfactory results, and, in addition, have employed this same modality in 40 cases of "active" acne vulgaris, also with good results.

While using Fluro-Ethyl** as local anesthesia for the removal of superficial seborrheic keratoses and molluscum contagiosum lesions, a persistent erythema and desquamation of the peripheral zones of each of the treated lesions was noted. This observation suggested the use of Fluro-Ethyl refrigeration in the treatment of selected cases of "active" acne vulgaris and postacne scarring.

Method: The face is cleansed thoroughly with acetone and alcohol. The ears are plugged with pledgets of cotton and the eyes are shielded. The can of Fluro-Ethyl is held about four inches from the skin and the spray is then directed towards the affected region until the site becomes hard and frosted. This usually occurs at the end of three or four seconds, and, as the sprayed areas begin to thaw, adjacent sites are sprayed until the entire region has been treated. Erythema occurs almost immediately and persists for three or four days. Desquamation results in about 24 or 48 hours and usually persists for another day or two. Local desquamating preparations are avoided during this period, and the patient is re-treated every 14 days until desirable results are obtained.

Summary and Conclusions

We have employed Fluro-Ethyl as an adjuvant in the treatment of acne vulgaris and postacne scarring. The results, thus far, have been encouraging. The treatment is inexpensive and has the advantage of being readily available in all communities. It is very practical as an everyday office procedure.

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**A refrigerant containing 25 per cent ethyl chloride and 75 per cent dichlorotetrafluoroethane, and manufactured by The Gebauer Chemical Company, Cleveland 4, Ohio.

Diabetes:

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

This 75 year old white man was first known to have diabetes in 1949. Moderately severe diabetic retinopathy and early cataract were believed to be responsible for reduction of vision. Acuity was recorded as O. D. 20/100 and O. S. H. M. when he was first seen in the Ophthalmology Clinic in 1952. Tonometer tension was 38 O. D. and 70 O. S. (normal less than 27), indicating that unsuspected glaucoma had been responsible for his visual loss. The right visual field was constricted to one third of the normal size. His pressure has been controlled through surgery and miotics, and no further loss of vision has ensued during the past six years.

Discussion

Presence of typical microaneurysms (tiny red specks smaller than the caliber of an arteriole on the disc) or of neovascularization (arborizing capillary and venous channels) in the fundus will often permit the diagnosis of diabetes through ophthalmoscopy. Characteristically situated in the region of the macula, diabetic retinopathy may be responsible for severe visual loss. Complaints of poor vision from such a patient are often answered with the discouraging recommendation that he should accept his infirmity. Similar advice may be given the diabetic who is developing cataract.

The symptom of gradual, painless visual loss in late adult life certainly warrants careful ophthalmologic examination. Through history alone it may be impossible to differentiate between presbyopia, cataract, macular degeneration, diabetic retinopathy, optic atrophy, or chronic simple glaucoma. Indeed, just as in the case presented, several of these diseases may coexist. Suprisingly often a careful refraction will improve vision markedly over that obtained with the patient's old pair of glasses. Just as any other patient over 40 years of age, the diabetic has a 2 per cent chance of having glaucoma. Early detection and control would have prevented glaucomatous loss of vision in the case reported.

Unfortunately diabetic retinopathy may by itself cause blindness. The course of diabetic retinopathy is variable, with exacerbations and remissions, but severe cases gradually lose vision despite all therapy. Anticoagulants, vasodilators, vitamins, diet, insulin, and a multitude of other medications have been tried without convincing results. Probably the most practical approach is the statement that this eye trouble is only a symptom of a general disease, and that proper regulation of the diabetes and general health measures represents optimal care. Many physicians believe that careful control of the juvenile diabetic will result in significantly less retinopathy. This belief is open to the question whether poor control might represent more serious disease which would have been more likely to produce retinopathy anyway.

Rather sudden onset of blurred vision is commonly seen in a diabetic who is going out of control or is subject to insulin shock. Hydration and dehydration alterations in the lens cause these changes of focus. Refraction done during a period of poor control will often result in prescription of unsatisfactory glasses. It is wise to delay refraction until after several weeks of good regulation of the diabetes.

Spontaneous massive vitreous hemorrhage without a history of trauma is most often due to diabetes, hypertension, blood dyscrasia, or retinal detachment. Etiologic diagnosis is often impossible through examination of the involved eye, for the fundus cannot be visualized despite good dilatation of the pupil. Commonly similar changes will be present in the "good" eye, and will permit accurate diagnosis. This is one example of the application of the useful precept, "always examine *both* eyes, even though the patient may complain of only one."

The Author

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Antibody Identification in Blood Bank Service

C. R. MACPHERSON, M. D., and M. J. CHRISTIANSEN, M. T., A. S. C. P.

AS the number of patients receiving blood transfusions increases, and more particularly, as the frequency of multiple transfusion increases, the problem of detection and identification of red cell antibodies becomes increasingly important. The *detection* of antibodies is of course the reason for the cross-match and is a process which is absolutely essential for any type of Blood Bank service. The *identification* of antibodies, although not of such obvious and immediate importance, is nevertheless an important aspect of Blood Bank function. This becomes more evident where the Blood Bank handles a large volume of blood and particularly where it serves a large obstetrical unit or a unit such as the Research Medicine Service of the University Hospital, Columbus, Ohio, where a high percentage of patients receive many transfusions over a long period.

Where antibody identification is not carried out, obtaining blood for patients who have antibodies depends upon a purely empirical process of cross-matching against a sufficiently large number of donor units until the desired quantity of compatible blood can be obtained. If the antibody is identified then a considerable saving of time and effort is effected, since it is much easier to type rather than cross-match a large number of bloods. This becomes even more obvious where the patient has devoloped several antibodies, as has happened in a considerable proportion of the cases reported here.

A natural development from the original Blood Bank functions is the detection of antibodies, particularly Rh antibodies during pregnancy. Where such antibodies are detected for the first time arrangements can be made to care for a possible erythroblastotic child. Detection and titration of antibodies during pregnancy is now a well established function of most Blood Banks.

Nature of Survey

The University Hospital Blood Bank has been systematically attempting to identify all antibodies encountered since April, 1957. This report covers the nine month period until December 31, 1957, during which about 11,000 transfusions were given. The technique employed is the use of a panel of eight cells, which have a known antigenic structure. These cells are supplied commercially by the Knickerbocker Foundation, of New York, under the trade-name "Panocell" and this organization has served as a reference laboratory to confirm, and in some cases extend, our findings, as has the Ortho organization, of Raritan, New Jersey.

The Authors

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● **Miss Christiansen, Columbus, technologist in Clinical Laboratories, is Supervisor of Blood Bank, University Hospital.**

The serum tested is, in effect, cross-matched against each of these eight cells and the reaction pattern obtained is compared with the table of antigenic structure supplied with the cells. In most cases the antibody can be readily identified but in some cases further study with specific cell types is necessary. Table No. 1 lists the antibodies found, and shows the service on which the patient was admitted. Table No. 2 shows the distribution of patients possessing multiple antibodies. Several of these antibodies are worthy of further comment.

One anti-M antibody was found in a woman whom we believe to have had an erythroblastotic child. This is the third known instance in which

TABLE 1.—*Distribution by Clinical Services of Antibodies Found*

Antigen Against Which Antibody is Directed	Total	Obstetrics	Research Medicine	Others
D (Rh_o)	30	25	3	2
C (Rh′)	7	2	4	1
E (Rh″)	3	1	1	1
c (Hr′)	1	1	0	0
e (Hr″)	0	0	0	0
V	1	0	0	1
M	2	1	0	1
N	0	0	0	0
Kell	4	0	1	3
Cellano	0	0	0	0
Duffy[a]	2	1	0	1
Kidd[a]	1	0	1	0
Lewis[a]	2	2	0	0
O (H)	1	1	0	0
Total	54	34	10	10

TABLE 2.—*Patients with Multiple Antibodies*

Case No.	Sex	Age	Blood Type	Service	Antigens Against Which Antibodies Found	Comment
1	F.	25	O. Neg.	Prenatal	D (Rho) & C (Rh′)	1 abortion, 6 pregnancies. Last child severely affected.
2	F.			Prenatal	D (Rho) & C (Rh′)	No information—specimen by mail.
3	F.	22	A neg.	Gynecology	D (Rho), Duffy^a, O (H)	7 pregnancies, no transfusions No affected children.
4	M.	57	O neg.	Research Medicine	Kidd^a, Kell	Multiple transfusions for hemolytic anemia. One mild transfusion reaction.
5	F.	47	A pos.	Research Medicine & Isolation	D (Rho), C (Rh′), E (Rh″)	No pregnancies or incompatible transfusions, hemolytic anemia.
6	F.	47	O neg.	Surgery	D (Rho), C (Rh′), V	Known to have been given O positive blood in emergency.
7	F.	62	A pos.	Surgery	E (Rh″), Kell	10 pregnancies, 1 unit of blood.
8	M.	19	O neg.	Research Medicine	D (Rho), C (Rh′)	Christmas disease. O pos. blood given in 1950. Titer maintained since.
9	F.	46	O pos.	Gynecology	E (Rh″), e(Hr′)	2 pregnancies, 1 abortion, 1 unit of blood 1955, 1 unit 1957, then developed antibodies.

this has occurred and will be reported more fully elsewhere.

One example of anti-Lewis^a came from a woman who had nine pregnancies and multiple transfusions and there is no way of telling which of these factors was responsible.

The anti-V antibody came from a Mexican woman who had had multiple transfusions. Only one of these, about three weeks prior to the discovery of the anti-V, was from a Negro donor. This antigen is almost confined to the Negro race and the association of anti-V with anti-C is very common. This particular anti-V is apparently the first example of such an antibody which is active in saline medium.

In Case No. 5, (Table 2), the patient who possesses anti-D, anti-C and anti-E, also possesses these factors on her red cells. She suffered from an acquired hemolytic anemia and a complete clinical remission was caused by splenectomy, although the immunological process still persists. This patient was originally reported to have anti-D and anti-E (Crowley and Bouroncle, 1956), but developed anti-C as well during a subsequent hospital admission. This case will be reported in more detail elsewhere.

Comparison of tables 1 and 2 will show that although the majority of all the antibodies detected have come from patients on the obstetrical service, a much smaller proportion of patients with multiple antibodies came from this service. This finding confirms the observations of others that if patients receiving multiple transfusions are capable of forming antibodies, they frequently do so to more than one factor. Another aspect of this problem lies in the fact that women who are sensitized during pregnancy are exposed to the red cell antigens of the fetus only, whereas those sensitized by transfusion are necessarily exposed to a much wider range of antigens.

Summary

Antibodies encountered during a nine month period in a large hospital Blood Bank are briefly reviewed. Fifty-four antibodies were identified in the course of 11,000 transfusions, and 225 antibody titer determinations from the Prenatal Clinic.

The largest percentage of all antibodies were encountered on the obstetrical service. The majority of patients developing multiple antibodies did so as the result of repeated transfusions.

It is emphasized that identification of antibodies has a strictly practical application, as well as theoretical interest. When antibodies are identified the problem of finding compatible blood is made much easier.

Studies of the 1957 Influenza Outbreak in Indiana

An epidemic of A/Japan/305 influenza occurred in Indiana during the period of September 28, 1957 and December 14, 1957. Infection first occurred among teen-aged school groups and then spread to grade schools and finally adults. Influenza associated mortality was high in the age group under one year and in the age group over 60. Most frequent cause of death was pneumonia. Pre-epidemic levels of reported influenza were reached by the end of 1957.

Vaccine first became available in Indiana on September 5 when 26,736 cc.'s were received. By December 27, 1957, a total of 830,645 cc.'s of vaccine was made available in Indiana. Thus, it is apparent that vaccine became available in very limited quantities prior to the October increase and became more plentiful for the remainder of the year.—*J. Indiana M. A.*, 51:637, May, 1958.

Multiple Test Technique for Early Detection Of Cancer of the Cervix

RICHARD B. SALZER, M. D.

THE importance of detection and diagnosis of early carcinoma of the cervix uteri cannot be overemphasized. Carcinoma in situ can almost invariably be cured and the cure can be effected by relatively simple means. Considering even some of the very highest five year cure rates reported for invasive carcinoma the desirability of treating in situ carcinoma becomes really apparent.

Stage I	80 per cent
Stage II	60 per cent
Stage III	25 per cent
Stage IV	9 per cent

The type of treatment required to effect a cure adds even more weight to the importance of early diagnosis. The standard treatment of choice for carcinoma in situ is a total hysterectomy removing a wider than usual cuff of vagina. In the younger women the ovaries may justifiably be allowed to remain. Even conization with very careful follow-up may be sufficient therapy in the young women who desire more children. These variations in treatment are quite important since the average age at detection of carcinoma in situ is only about 36 years.

Then too, one cannot help but be impressed with low morbidity and mortality associated with total hysterectomy when compared with the serious and frequent complications and annoying after effects of either radical surgery or full irradiation treatment which is required for clinical invasive carcinoma.

There is growing evidence that the very early invasive carcinoma of the cervix, also termed preclinical invasive carcinoma and microinvasive carcinoma, is more closely allied to carcinoma in situ in regard to age incidence, cure rates, and type of therapy necessary than to carcinomas usually classified as Stage I (I. C.). By definition, however, these are actually Stage I lesions. These lesions can be found only by refined techniques of diagnosis but in large part can be diagnosed by methods which are available today. Philosophically, if there were some way to have all women report for frequent and thorough detection studies and if we, the doctors, would always perform all the indicated tests, invasive carcinoma of the cervix as we know it today could become a disease of the past.

Great steps can be made toward this goal if all women for whom pelvic examinations are performed would receive the benefit of a complete and systematic study of the cervix using all the available methods of early cancer detection. Fortunately the techniques which are available are painless, relatively inexpensive, and consume very little time.

The Author

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I will summarize some of the advantages and disadvantages of the various methods which should be used:

Biopsy

1. Biopsy is the last used but the most important of the methods. The biopsy with careful pathologic study is the only method by which a definite diagnosis of carcinoma can be reached. It is of necessity the last step in our study since all other techniques tell us only when, where, and how to perform the biopsy.

Random biopsies, especially multiple ones such as with the "four quadrant plan," whether the cervix appears normal or not, will detect a large percentage of early carcinomas. When, however, we consider the tremendous number of negative results which would ensue, we can appreciate the cost both in money and time for preparation and examination of the specimens. Then too, even with the taking of four, six, or eight punch biopsy specimens, areas of the remaining epithelium could harbor very small malignancies.

Indicated biopsy of any lesion grossly visible, results also in large numbers of negative reports. One again may geographically by-pass a malignant area while removing part of a benign lesion. Circular biopsy or sharp conization cannot be done on every patient whether a visible lesion is present or not, due to the required hospitalization, anesthesia, etc. It, of course, must be done when questionable results are obtained from punch biopsies or other diagnostic studies.

The Cytologic Smear

2. Development of the technique of cytologic examination of the smears from the cervical epithelium has made a tremendous change in our

thinking and practice pertaining to carcinoma of the cervix case-finding and too much praise for the help which the Papanicolaou smear provides cannot be given. Nevertheless, this tool does leave some things to be desired. If positive or questionable smears are obtained either in the presence or absence of grossly visible lesions, the same difficulties regarding site of biopsy are encountered.

At best, false negative results occur in about 10 per cent of cases later proven to have carcinoma. In personal communication with an excellent cytologist (Dr. James Rollins) who also practices colposcopy, I learned that his accuracy in cytologic diagnosis was greatly increased by taking extra time and care in screening the slides of cases which also had exhibited suspicious colposcopic findings.

Colposcopy

3. Colposcopy, by filling in information which is still missing after use of the other tests, is an extremely valuable tool in early carcinoma detection. Used alone it approaches cytologic diagnosis in accuracy but for the best advantage it is used in conjunction with the cytologic studies and other methods. The biggest disadvantage to colposcopy in this country at the present seems to be first, the lack of instruments and second, the paucity of trained colposcopists. Basic colposcopy is not too difficult to learn, but as with everything else in medicine, the value of colposcopic examination increases with the ability, training, and experience of the colposcopist.

By three dimensional visualization of the cervix through this binocular instrument under brilliant light a whole new world of cervical anatomy is encountered. Lesions too small to be seen by the naked eye are found and what grossly appears to be normal epithelium can be seen under the colposcope to be a hyperplastic type of epithelium. In larger areas of visible erosion one can differentiate distinctive small areas of which a biopsy is indicated if such be present. Many of the "erosions" which would have to be biopsied can be seen to be misplaced columnar epithelium, termed ectopy, or areas of admixture of non-hyperplastic columnar and squamous elements called transformation zone. Much else can be visualized with the colposcope but the scope of this paper does not permit its detailed description.

Generally, then, the colposcopic examination will not diagnose carcinoma but it will detect and differentiate from other lesions and normal epithelium, atypical and hyperplastic lesions of the exocervix and distal portions of the endocervical canal. These hyperplastic lesions represent anything from mild basal cell hyperplasia to invasive carcinoma and only tissue study will determine the degree of atypicality.

The Schiller Test

4. The Schiller test is a rather crude method of diagnosis since failure of cervical epithelium to stain deeply with an iodine containing solution indicates only abnormality and not type or character. Its only value when used in conjunction with these other tests is as a check on the human element of colposcopy. No information can be added to the colposcopic examination by the Schiller test but due to the vagaries of human perception the iodine staining of the cervix will show that no abnormal area has been overlooked during colposcopic examination.

Gross Visualization

5. Gross visualization is probably the least informative method for detection of the early carcinoma. Not only are the early lesions often too small or too indistinct to be picked up by this means, but also so-called "erosions" may be benign completely or have areas of malignancy within their confines. There is no way of suspecting which of these possibilities exist by gross examination. If none of the other methods is available or is used, biopsies should be taken of all "erosions." Again, the actual area of malignancy, if present, may be overlooked.

Summarization of Multiple Test Technique

In the way of summary then, the following is a list of steps which I suggest for early detection of carcinoma of the cervix:

1. Speculum is inserted and a quick visual survey of the cervix and vagina is made.
2. The cervix and vagina are examined colposcopically.
3. A cytologic smear is made containing material from the lower endocervix and the portio vaginalis using an Ayre spatula or similar instrument.
4. The cervix is wiped off with a sponge saturated with dilute acetic acid and colposcopy is repeated.
5. If squamous epithelium is seen to be growing up into the endocervical canal beyond visualization, a tiny curette is used to obtain endocervical tissue which is sent for histologic examination.
6. The cervix is stained with Schiller's solution and repeat colposcopic examination done if indicated.
7. Punch biopsy under colposcopic control is performed if indicated.

Using this multiple test technique I feel that early carcinoma of the cervix will be overlooked as close to "never" as is possible in medicine.

The Medical-Legal Relation of Injury To Spinal Arthritis

THEODORE A. WILLIS, M. D.

AN orthopedist who has not been subpoenaed as a witness in litigation involving injury and arthritis of the back may look forward to that experience with certainty. He may expect with equal assurance that in this event the plaintiff will endeavor to extract from him testimony in excess of the truth, while the defendant will attempt to suppress aspects of the truth unfavorable to his cause, the spoils of war in this parliamentary contest of wits being, not justice, but a court award which, whatever it may be, will be considered exorbitant from one viewpoint, inadequate from the other, in relation to the actual damage sustained by the victim of the accident.

The story, as so often told, is this: An individual is referred to a physician for examination and report concerning the degree of his disability and an estimate of the percentage of this attributable to an accident incurred two or three years previously.

According to the victim's statement, he had been in perfect health until he had strained, bumped or twisted his back in the course of his employment, or had been involved in an accident. Immediately, or perhaps within a day or two, pain had developed in his back. He reported the circumstances to his boss and was seen by his own, or the company doctor who diagnosed a sprain, contusion or lumbago, and advised rest, heat and aspirin. In a few days he was considered fit for work but still complained of pain with activity and refused to return to his job which entailed lifting, bending or agility of movement. The employer would, or could, offer no lighter work and the stage was set for a deadlock. After a period of idleness, the victim consulted a lawyer of reputation in personal injury claims who referred him to a physician of court reputation. At this time x-rays showed "arthritis" or some other common abnormality of the vertebral column.

There are now two strikes against the insurer; no immediate x-rays had been made or, if they had, no attempt had been made to explain to the patient and the insurer preexisting conditions that might have been aggravated by the injury or delayed recovery from it. No effort had been made to fit him into a job that would serve until the temporary effect of the injury had subsided. The third strike is sure to be called by the jury when these peers have been convinced by the plaintiff's expert witness that he is totally and permanently unable to resume his former occupation because of the arthritis or other abnormality claimed to be caused or aggravated by the injury.

Presented before the joint meeting of the Robert Jones Orthopaedic Society and The Orthopaedic Club, in Cleveland Ohio, May, 1957.

The Author

● Dr. Willis, now retired, was formerly head of the Department of Orthopedic Surgery at St. Luke's, Charity, and St. Alexis Hospitals, and former consulting orthopedist, USPHS Hospital, Cleveland.

Joint Reactions to Injury

Joint structures react primarily to physical injury in the same manner as to other irritants, such as bacterial infection or metabolic toxins, with heat, pain, edema, increased production of synovial fluid, restriction of mobility and protective muscle spasm. If the irritating agent is transient, as is a single trauma, the reaction is temporary and, if allowed rest and protection, gradually subsides. It the joint is further irritated by undue activity, disturbed dynamics or interruption of its blood supply, the symptoms persist and progress.

Such a course is readily observed in the more accessible joints of the limbs and is diagnosed *Traumatic Arthritis*. The intervertebral joints are deeply situated and well protected from direct contusions but are subject to sprains. If their dynamics are disturbed, mechanical irritation persists and an acute arthritis caused by a single injury may become chronic.

All types of arthritis have been attributed to injury. Theoretically, pathogenic bacteria circulating in the blood or lymph, or quiescent in contiguous bone, may be localized in joint tissues by trauma and develop acute or chronic infections according to their natures. Whether or not one concurs in this theory, it has been recognized in court. While it cannot be categorically denied, one

must insist that such *Infectious Arthritis* originates at the site of injury and follows a course characteristic of the invading organism in chronology, systemic and pathologic symptoms. Unless compounded, injury alone does not cause infectious arthritis. At most it may localize or aggravate a preexisting infection.

Chronic arthritis, either infectious, traumatic or metabolic, may be well established before injury calls attention to it. It must have been present for some time before tissue changes are shown by x-ray.

Emotional Element of Arthritis

Rheumatoid Arthritis, one of the most prevalent of chronic diseases, is an inflammatory lesion of unproven etiology which may be present but unrecognized until activated by trauma, exposure, fatigue or even by depressive emotional crises. This is a systemic disturbance, its joint symptoms apparently due to a presently unidentified protein toxin of metabolic orgin to which specialized connective tissues are particularly susceptible.

That this conjectural toxin may be increased, or that the individual patient's detoxifying function may be diminished, by prolonged emotional depression, is a frequent observation. The writer has so often seen both subjective and objective symptoms of an arthritic patient, who had been progressing satisfactorily, seriously aggravated following advent into the home of a critical or domineering relative that he has been tempted to dub the condition "Mother-in-law's Disease." The balance of health is similarly upset by social, financial or economic stresses, and the symptoms frequently subside when the irritant is removed or psychological adjustment has been made to it.

Small wonder then that, in susceptible individuals, emotional depression due to injury, loss of employment and loss of income so frequently obligated to credit buying, starts a vicious circle activating rheumatoid arthritis. Though not caused directly by injury, this type of chronic arthritis is liable to aggravation by either physical or mental factors.

Misnamed osteoarthritis is characterized by medullary osteoporosis, calcification of ligaments and friabilization of cartilage, all of which are degenerative, not inflammatory, changes associated with vascular stasis. They are frequently seen in x-rays of backs of individuals who have been performing heavy labor with no evidence of disability. Such changes are certainly not caused by a single injury, but their presence indicates predominance of degenerative processes and susceptibility of the back to injury with delayed recovery.

What about the calcifications that we point out to patients roentgenographically, sometimes I fear, giving them the indelible impression that here is the source of their pain and disability? In 1924[1] the writer discussed them as found in the macerated skeletons of 625 dissecting room subjects, arriving at the conclusions that they were signs of age appearing at about the 35th year and progressing steadily with time; that they appear earlier and develop more extensively in broad, heavy vertebrae, and that clinical experience indicates that strenuous physical activity accentuates their growth. He still maintains these opinions and believes that, when pronounced, the degenerative condition of which they are evidence affects the stability, mobility and vulnerability to injury of the vertebral column, but that if pain appears injury or rheumatic complications are to be suspected.

Macnab, Harris and Lauren[2] have recently stated that these spondylophites, of which they describe five types, are always associated with degenerated intervertebral discs; that they form and progress only in the presence of local movement and, since they ultimately immobilize the vertebral joints, are self-limiting. They find no constant relationship of spondylophites to posterior vertebral joint arthritis, and attribute any pain associated with them to anatomical instability or arthritis.

Medical-Legal Concurrences

The relationship of vertebral arthritis to injury is primarily a medical problem, but due to its legal implications, has acquired major importance in personal disability litigation. Medical opinion is in general, founded on experience, the success or failure of various procedures to relieve a patient's complaints, and is constantly changing with new discoveries. Legal opinion, though progressive, is founded largely on precedent, decisions arrived at in previous considerations of similar problems. The two professions have arrived at certain agreements in respect to the problem under discussion. For instance:

The Swiss National Accident Fund[3] has decided that:

1. The fact that the patient had no incapacity before the accident is not absolute proof that the joint was previously intact, but a roentgenogram showing arthritic deformity is proof of previous latent disease.

2. Arthrosis may follow an accident that is particularly violent, causes marked damage to cartilaginous structure and is followed by serious local trophic changes or prolonged irritation.

3. Minor traumas, such as torsions, contusions and injuries to soft parts cannot possibly cause

deforming arthropathy, but may set off an attack if the disease existed previously.

4. A bout of arthrosis following trauma will usually subside under proper care, and joint function will be largely restored.

5. In general, only those joints directly injured will be the site of post-traumatic arthrosis.

6. The disease rarely spreads to neighboring joints, even if they form a static unity with the involved joint.

7. The lapse of time between injury and the first clinical or roentgenological manifestations of arthrosis is determined by the nature and extent of the injury and the age and susceptibility of the patient.

8. If post-traumatic arthrosis disappears completely, the accident cannot ordinarily be invoked as the cause of future attacks of arthrosis, especially if they do not occur until much later.

9. Arthrosis is a disease of wearing out and is therefore more truly pathological when appearing in younger folks.

The Ontario Workmen's Compensation Board[4] has arrived at conclusions quite similar to these:

1. Degenerative arthritis of the vertebral column occurs frequently after the age of 35 but is essentially asymptomatic in 80 per cent of affected individuals. Radiological changes are proof of the disease but have no correlation with the presence of disabling symptomatology.

2. Trauma may aggravate a preexisting arthritis and be responsible for its exacerbation for an arbitrary period of six months.

3. Trauma is not recognized as the cause of arthrosis or of aggravations recurring 6 to 36 months after the injury.

4. The board accepts a limited degree of responsibility for arthritis associated with intervertebral disc injuries, fractures and spondylolisthesis. Also for arthritis associated with and localized at, vertebral fractures, disturbed joint dynamics, aseptic necrosis and nonunion.

5. The Board finds no proof that Marie-Strümpell disease is speeded up by trauma.

6. Trauma does not play a role in the development of rheumatoid arthritis but may aggravate a preexisting lesion.

7. Gout is not caused by trauma but trauma may aggravate or precipitate an attack. Responsibility is accepted for the original attack only.

Medical-Legal conclusions in the United States are closely in agreement with the foregoing opinions and have been well summarized in the following citation by the Supreme Court of the State of Washington[5]: "Where a compensable injury lights up a dormant or quiescent arthritis the injured workman may be compensated for the full extent of the disability occasioned by the arthritis so lighted up." Then this pertinent sentence is added: "The extent of the disability attributable to compensable injury, as it exists at any relevant time, must be determined by medical testimony, some of which must be based on objective symptoms."

Here is the crux of the problem, dropped squarely in the lap of the medical profession. Here is the test of a medical witness's intelligence and integrity; his ability to render an opinion based wholly on his professional knowledge, regardless of personal interest and motives.

Proof of Disability

Estimation of the degree of disability attributable to arthritis or to injury of the back, or of the aggravation of one by the other, may be difficult or impossible, even if there exists a record of the pre-traumatic condition of the back. Meticulous disability rating schedules have been prepared and are of value as general guides, but ultimately each individual claim is reduced to careful appraisal of subjective symptoms and comparison of these with any objective evidence available and with the victim's pre-traumatic record if, by good fortune, such exists.

Disability of the joints of the extremities can be demonstrated and estimated in relation to stability and mobility of the part, but how important is mobility of the back? Assembly-line workers, machinists, stenographers, even professional weight lifters perform with their backs straight. A back ankylosed in extension by Marie-Stümpell arthritis is not severely disabled if the neck, shoulders and hips are mobile.

Stability is a more important back factor than is mobility, but how can one satisfactorily manipulate a back to determine it? In no other part of the body is an examiner so dependent upon subjective symptoms and x-ray findings. In no other part do x-ray films show so many abnormalities that may, or may not be of etiological import.

When there has been a fracture or other diagnosable injury the ensuing disability can be estimated with a degree of confidence, perhaps by recording the degrees of deformity, mobility and stability on punch-cards and feeding them to a computing machine. Unfortunately there will still be differences of opinion among the card punchers. Even greater will these differences be when

the injuries are less definite and are associated with arthritis and other complications.

Long periods of disability are almost certain to be associated with exaggeration and malingering. These can be detected by careful observation. Only a well instructed expert can assume the attitudes characteristic of back injuries, and he cannot maintain them while performing the movements required in back examinations. Refusal to attempt such movements is as reliable evidence of malingering as is invocation of the fifth amendment in political trials.

The borderline between actual and conscious or subconscious exaggeration of disability is indistinct and here is a field for honest divergence of medical opinions. Here too, is a fertile and safe field for propagation by the occasional unethical and dishonest physician and attorney. How can one disprove the veracity of an expert opinion stated under oath? A hospital tissue committee may prove errors of diagnosis and judgment, and withdraw a physician's hospital privileges because of them, but it cannot disprove his sincerity in making them. A medical society's investigating committee may disagree radically with a witness's expressed opinions but it cannot well prove they were perjured.

A juror is justifiably confused by the contradictory testimony of medical expert witnesses, and by testimony couched in technical terms and jargon. Having no knowledge of anatomy, physiology and pathology, he is more impressed by the witness's personality and assurance than by the substance of his testimony. He is apt to consider the less convincing witness a member of a partisan team rather than impartial.

A Court Appointed Expert Witness

If the court considers the testimony of medical witnesses too divergent to represent honest differences of opinion it has the authority, subject to the laws of its state, to subpoena and remunerate experts of its own choice. It is probable that jurors would give more weight to the testimony of a court appointed expert than to those whom they must consider partisans.

I suggest that this judicial privilege be employed more frequently. The court appointee should be allowed to examine the patient and review the testimony of the other physicians and confer with them personally if he so desires, before taking the stand. Still better, because once testimony is recorded it cannot well be changed, when it is known that there will be radically differing opinions, the court appointment and medical conference, including examination of the patient in the presence of the opposing attorneys as silent observers, could precede taking of medical testimony. I doubt that a partisan witness, if there be such, would venture so far out on a limb of biased opinion under such circumstances as he might otherwise. No witness would be bound in his testimony by the opinion of the conference but consultation is a valuable procedure in any medical problem and might lead to more careful consideration by all of the experts.

A number of state and county medical societies have attacked the problem of medical testimony. Minnesota, for instance, has had for a number of years a committee with authority to review trial testimony, to confer with the witnesses and report to the society any questionable findings. The New York Academy appoints a panel from which witnesses may be chosen by the Court.

Plans of this sort should be universal and based on the local state laws, some of which probably need altering. The committees should investigate as thoroughly as possible the instigation of each suit. Many are due to inconsiderate action by the physician, some to unethical legal practices, others to the intolerance of either the plaintiff, defendant, employer or insurer.

I suggest also that attorneys handling personal injury claims, during examination and cross-examination of medical witnesses, make sure that even the dullest of jurors understands the problem under discussion and the statements of the witnesses. This can be better accomplished by insisting that technical language be avoided as much as possible and by presentation of anatomical material, models or colored charts illustrative of the parts involved. These could be prepared by health museums or medical schools and made available by loan, rental or subpoena.

Detrimental Effect of Litigation

Three parties are originally concerned in the problem of injury and spinal arthritis: the patient, the physician and the employer. The most important objective in the viewpoint of all three should be prompt and efficient treatment of the patient. This implies meticulous examination and recording of all findings, including x-rays, no matter how minor a back injury may seem; frank discussion with the patient and the insurer, in understandable language, of the injury and of preexisting conditions such as arthritis and anomalies that may affect the progress of the patient and his restoration to useful employment.

If there is to be a permanent disability, either partial or total, a prompt settlement of the claim directly with the patient is best for all concerned.

Every effort should be made to avoid litigation and the deleterious effects of two or three years of vindictive idleness and exaggeration of symptoms, during which the patient's employability and morale are disintegrating.

Certainly an employee or insured individual who has legally proven, or even attempted to prove, himself partially or permanently disabled, is handicapped in obtaining further employment or insurance. By litigation he has also gambled his claim for rehabilitation and job adjustment and his medical expenses against an uncertain number of dollars. Of even more importance, he has compromised the moral stamina necessary for his resumption of normal living.

Though 95 per cent of personal injury claims coming to litigation against railroads are decided in favor of the plaintiff, he may well be better off financially through direct settlement of his claim with the defendant, and at the same time escape the detrimental effect of litigation. Two hundred and four personal injury claims, including fatalities, single and double amputations, were settled directly with claimants by five railroads in different sections of the country for an average of $21,541.99. The estimated net proceeds for the victims of 255 similar accidents settled by litigation averaged $19,949.74[6].

From the court award, if he wins the contest, the claimant must subtract one-third or one-half for his attorney's fees, and if not insured, the costs of his treatment, also the intangible physical and moral effect of the long period of inactivity and the detriment to his future employment. The defendant must add to the court award the costs in money, time and employee morale of defense. The only clear profit from litigation is that of the plaintiff's attorney, usually contingent upon victory, and of the expert witnesses, which is at times a bit odorous.

Responsibility for Injury

The claimant must realize that his injury was accidental, perhaps due to his own carelessness; the employer, that the workman was injured in his service and must be restored to useful employment; the insurer, that his policyholder is entitled to the protection for which he has paid. The attorney must know that greed and malingering are not to be condoned and that prolonged idleness and exaggeration of disability are harmful to his client far beyond the value of additional dollars that may be acquired by litigation. The physician must remember that it is his duty to restore his patient to useful activity as rapidly as possible, not to pervert the truth to win court decisions either for or against his patient.

Finally, the court must discover a means of lessening the delay in hearing those personal injury claims that come to litigation; a delay extremely detrimental to all parties concerned in the problem.

Summary

One of the most frequent and difficult problems of personal injury litigation is determination of the degree of disability following injury of an arthritic back, the relation of the arthritis to the injury, and the percentage of disability attributable to each of the factors.

Though all types of arthritis have been claimed to be caused, or at least aggravated, by injury, the type most often involved is osteoarthritis, the degenerative lesions of which appear regularly in middle age and are shown in x-rays as osteophytes, calcifications and thinned cartilages.

An aging back is more susceptible to injury and slower in recovery therefrom, but the effect of injury is temporary unless the dynamics of the back are disturbed.

Complex rating schedules are of but little value in determining back disability because the symptoms are mostly subjective, x-rays show degenerative changes and abnormalities that may, or may not, be of etiological importance, and because claims of disability that drag through litigation are certain to involve conscious or subconscious exaggeration of symptoms or even deliberate malingering.

Meticulous examinations may lead to honest divergence of medical opinions that confuses jurors. Testimony of a witness appointed by the court and intelligently presented would no doubt aid these peers in arriving at a reasonable verdict.

For the physical, moral and long term financial welfare of the patient, and for the good of the employer and insurer, it is best to settle personal injury claims promptly and fairly without litigation. Medical and legal organizations must continue their efforts to aid the courts in discouraging the occasional shyster and perjurer who pervert justice for financial gain.

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TOPIC THIS MONTH:

Maternal Deaths* Involving Pulmonary Embolism

Case No. 152

This patient was a 28 year old Para II, abortus I, who died 10 days postabortal. Her past history showed the patient had had hypertension three years previous, during her first pregnancy in 1953. Little is known concerning her treatment at that time. The first and second pregnancies were presumably delivered at term, with toxemia the sole complication. Her last menstrual period was November, and, according to the data available, she made only one prenatal visit to her physician. The date of this visit is not known.

It was stated that her blood pressure reached a high of 220/130, and albuminuria and edema are not noted. The details of the onset of her labor are not known. She was admitted to the hospital on February 19, with apparent hypertension, although details of her physical examination are not known. It was stated that the patient was markedly obese. Laboratory studies are not reported.

Upon admission in her fifteenth week of pregnancy she was placed under extensive treatment and Ansolysen,® after a trial with other therapy had failed. Details of the treatment and laboratory procedure are not available. Finally, her blood pressure diminished rather rapidly, and after the medication was stopped the patient failed to elevate her blood pressure again. A renal shutdown ensued. The nonprotein nitrogen of the blood elevated; electrolyte balances became unstable, and the patient spontaneously aborted on March 12 (at 18 weeks). Details of these facts are not recorded.

With the patient later demonstrating relative hypotension, Levophed® was administered, blood pressure was maintained just above shock, but it could not be sustained for any length of time. The last nonprotein nitrogen of the blood was 156 mg. On March 21 she suddenly expired. Autopsy permission was not obtained.

Cause of death: Acute pulmonary embolus; phlebothrombosis, pelvic; spontaneous abortion (20 weeks); malignant hypertension; acute renal failure; paralytic ileus.

Comment

Members of the Committee felt markedly hampered in their efforts to properly evaluate the features in the case because of the lack of adequate details in the history, physical findings and laboratory work. It is regrettable that an autopsy could not have been performed to more clearly diagnose the cause of death. The question of nephritic syndrome developing prior to demise of the patient was properly raised. The Committee further raised the question of whether or not appropriate therapeutic agent was employed, in view of the pathological and physiological features in the case. It was also felt that the patient should have been advised not to become pregnant for a third time, in view of the severe hypertension that she previously experienced. Considering the meager facts and features presented, the Committee voted this a preventable maternal death.

Case No. 182

This patient was a 37 year old, Para XI, who died six days postpartum. She had 10 previous pregnancies, with no history of any difficulty recorded. Her past history was not known, and her last menstrual period was not recorded. She did not seek prenatal care, but was first seen by a physician for this pregnancy at term on the delivery table on June 30. Essential physical findings were: obesity; blood pressure 180/110; severe varicose veins of the legs, and internal and external hemorrhoids. Labor progressed uneventfully and with open drop ether anesthesia administered by a nurse, she delivered a stillborn infant weighing 8 pounds, 6 ounces. On July 1 the patient signed her release and left the hospital.

July 6 the patient was again seen in the emergency ward in extremus. No interim history could be obtained. Death ensued without the opportunity of any treatment and was attributed to pulmonary embolus. Autopsy permission was not granted.

Cause of death: Pulmonary embolus; obstetrical delivery.

Comment

The Committee voted this a preventable maternal death classified as the patient's responsibility. The possibility of development of thrombosis in the legs, hemorrhoidal vessels or in the pelvic vessels was seriously considered. Again, the Committee was hampered in evaluating the details in the case, since there were only meager data available and

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

no autopsy. The patient's responsibility was assessed in this case because of her lack of prenatal care and her insistence on being discharged after the delivery, although with meager facts available, it was hard to construct a physiological or pathological process preceding death. It was felt that had she presented herself to a physician at an early date for examination the thrombotic phenomenon might have been anticipated and a pulmonary embolus might have been prevented, if that was the cause of death.

Case No. 192

This patient was a 22 year old, Para III, who died 54 hours postpartum. In her past history there was nothing remarkable. However, she had had two previous cesarean sections at term, which were believed to be classical; indications not available. The first was complicated by postoperative bronchopneumonia. The date of the patient's last menstrual period is not known. However, the patient is believed to have had adequate prenatal care, with 10 visits to her physician's office.

According to the information obtained, the patient was admitted (near term) to the hospital August 5 for an elective cesarean section the following day. No details are given concerning her physical examination or her laboratory work. On August 6 the patient submitted to an elective classical cesarean (repeat) section under vinyl and ethyl ether anesthesia. According to the record, this was administered for 75 minutes. A living 7 pound 6 ounce baby was delivered without immediate complications.

At some time after the operation, the patient developed pneumonitis and bronchiolitis on the right side. She was immediately placed on Alevaire,® penicillin, and streptomycin. Her general condition temporarily improved. On August 7, the patient developed supraventricular tachycardia with regular pulse; pulmonary condition seemed to improve. She developed gastric dilation, and nasal suction was started. Panmycin® was administered, and on August 8 at 1 a. m. the patient was resting comfortably. Her pulse was rapid and regular; her color was pasty. Suction working well with soft abdomen. Rales and dullness were exhibited over right lower chest. At 1:30 p. m. there was sudden deterioration, marked cyanosis and dyspnea. The patient died at 1:35 p. m., August 8. There was no autopsy.

Cause of death: Pulmonary embolism, postoperative; supraventricular tachycardia; pneumonitis, postoperative; cesarean section.

Comment

Again, the Committee was profoundly hampered by the lack of detailed information concerning examination of the patient and by a lack of authentic information. Members of the Committee wondered if consultation had been obtained prior to this operation, in view of the pulmonary complications following the first cesarean section. Since the patient was assumed to be in good health and excellent condition prior to her operation, it is only a matter of conjecture to ascertain the source of the embolus, if that *was* the cause of death. Again, in view of a history of pulmonary complication, the wiseness in a choice of an anesthetic was questioned. However, in view of the facts presented, the Committee voted this a nonpreventable maternal death.

Comment of Consultant

The following comment of a consultant, a specialist in thoracic and cardiovascular surgery, was given at the request of the Committee.

To blame pulmonary embolism as a cause of sudden death without postmortem examination is fraught with danger. Most of us are aware of many patients who have died suddenly and in whom our pre-autopsy diagnosis was pulmonary embolism. Examination, however, would show a different cause for death or in many instances no exact cause could be visualized. In like manner, many cases of sublethal embolism take place without being diagnosed. The classical symptoms of shortness of breath, sudden chest pain, pleural friction rub, and hemoptysis are found in only 15 per cent of the cases which are proven by autopsy. Similarly, the wedge shaped pulmonary shadow seen on x-ray examination is the exception rather than the rule. The pain and tenderness over the deep veins of the calf may be quite minimal at the time a loosely fastened clot is released into the venous stream. And how does one diagnose an early thrombus floating in the pelvic veins?

The surgical removal of massive pulmonary embolus from the pulmonary arteries has proven to be unsatisfactory. Present-day measures consist of treatment similar to that of acute coronary occlusion.

For a time there was much talk and a beginning series of bilateral femoral vein ligation immediately following a suspected pulmonary embolus or even as a routine preoperative measure. Subsequent autopsy studies of McLachlin and Paterson showed that 50 per cent of the thromboses were located in the deep veins and that bilateral femoral ligation would not guard against pulmonary embolus. Vena cava ligation had its proponents also but the increased morbidity of this procedure has decreased its value.

At the present time the cycle has returned to its starting point, that of anticoagulant therapy. Coon et al. reported in the February, 1958, issue of *Surgery, Gynecology and Obstetrics* on the exhaustive study at the University of Michigan. Among the total of 511 patients, 21 had pulmonary emboli during anticoagulant therapy, causing seven deaths. After anticoagulant therapy was discontinued, 16 additional patients were diagnosed as having pulmonary emboli, with eight deaths.

It was equally discouraging to learn that (1) initial heparinization, (2) duration of anticoagulant administration, and (3) the level of "prothrombic activity" have no critical influence on the

rate of complications from peripheral venous thrombosis. The article ends, however, by stating that different authors report a decrease of 50 per cent in mortality and morbidity in comparison with a series of patients with no treatment at all.

Case No. 152: Implicating pulmonary embolism as a cause of death in a patient such as this with renal shut down is debatable. In fact, these patients generally show just the opposite, namely difficulty in controlling hemorrhage from operative wounds, skin, and mucosal surfaces. This is preceded by a lowered prothrombin, lowered platelet count and an increase in capillary fragility.

The duration of hypotension necessary to produce renal shut down is certainly less than 30 minutes and can readily take place during anesthesia in an arteriosclerotic patient with moderate blood loss or in a debilitated patient with a low blood volume. Although one can never accurately predict a patient's reaction to any certain drug, the rate of administration of the drug could possibly have been altered to obviate any sudden changes in blood pressure during the administration of this hypotension producing agent. Lowered cardiac output with resulting impaired venous return is a perfect setup for venous thrombosis. Without any symptoms of pulmonary embolism except sudden death, I fail to see how death from this cause could be prevented. However, I think the death was preventable on the basis of overtreatment of hypertension with a hypotensive agent.

Case No. 182: One might reason that if this patient's legs were wrapped with elastic bandage for the first two weeks postpartum, the chances of phlebothrombosis and thrombophlebitis occurring would be lessened. However, to routinely treat all postpartum patients having varicose veins and hemorrhoids with anticoagulants would be unsound. One tenth of all patients treated with these agents will experience bleeding tendencies of such magnitude that proper countertherapy becomes necessary.

It would be interesting to know if this patient practiced early ambulation like one might expect since she signed her release. Early ambulation to varicose veins without external support is probably as dangerous as bedrest with elevation of the leg. On this basis, death was possibly preventable.

Case No. 192: A history of bronchopneumonia following the initial section should weigh heavily in one's choice of anesthesia. Spinal anesthesia does not obviate pulmonary complications but does lessen their incidence. In addition, strenuous postoperative positive pressure breathing, forced laughing, aerosolization of antibiotics and the parenteral administration of antibiotics should have been given as a routine upon awakening rather than waiting until the patient became symptomatic. The value of endotracheal intubation for endobronchial suction as well as oxygenation should be kept in mind if general anesthesia is undertaken. The rapid onset of symptoms in this patient within 24 hours of delivery makes the diagnosis of pulmonary embolism doubtful. Aspiration pneumonia or bronchopneumonia would seem much more likely, and on this basis I believe the death was preventable by changes both in anesthetic techniques and in immediate postoperative care.

Selective Readings

The Riddle of Stuttering, by C. S. Bluemel, M. D., ($3.50, *Interstate Printers and Publishers, Danville, Ill.)* There are a number of components to the riddle of stuttering. The personality of the speaker must be considered. As a rule the stutterer is self-conscious, tense, excitable, and easily confused. Because of these characteristics—and because of speech phobia which develops later—there is a good deal of "fluster and scatter" in the verbal thinking and thus the mind may be mute when the stutterer attempts to talk. Not understanding these inner difficulties, the speaker attempts to force the articulation of his words, and the effort leads to struggle and contortion. This physical manifestation of the impediment is merely the empty shell of speech. Apart from this impediment, the stutterer is basically a poor speaker. Many stutterers have articulative difficulties in childhood, and as adults they carry a natural speech deficit. Even when a stutterer is talking well he seldom commands normal verbal skills.

Fortunately, therapy is much simpler than the complex structure of the disorder. The speaker does not need to work on his stuttering, he scarcely works on his speech. The therapy is directed to the verbal thinking process and if the stutterer can learn to think quietly and clearly in words, he can then broadcast words to his mouth. Such is the scheme of techniques given in detail in this work.

Albert Schweitzer: The Story of His Life, by Jean Pierhal. ($3.50. *Philosophical Library, New York 16, N. Y.)* Albert Schweitzer is one of the few "universal" men of our time. He has contributed equally to theology, music, medical science, philosophy and sociology. The new authorized biography of this most unusual man describes his childhood experiences, his researches and travels, his suffering and dedication and makes fascinating and inspired reading.

Proceedings of the Ohio Society of Pathologists

Reported by PAUL N. JOLLY, M.D., Cincinnati, Ohio

THE fall meeting of the Ohio Society of Pathologists was held at the Cincinnati General Hospital at 2:00 p.m. on Saturday, September 21, 1957.

Scientific Program

The first of four papers in the Scientific Program was presented by Dr. Benjamin Landing of the Children's Hospital. His subject, "The Histochemical Analysis of Anterior Pituitary Cell Types" indicated an attempt to localize the formation or storage of the known anterior pituitary hormones to the three anterior pituitary cell types. Two methods of study were combined to this end. The first was the histologic and histochemical study of the anterior lobe before and after various digestion and extraction methods. The second was the histochemical study of the various reactive groups of four of the anterior lobe hormones. The accumulated data separated four to eight proteins in the acidophiles and three to four proteins in the basophiles. None of the proteins so separated could be equated with any known animal hormone of anterior pituitary origin.

"Histochemical Study of Enzyme Activity of Leukocytes in Health and Disease" was the subject presented by Dr. Herbert Braunstein of the Cincinnati General Hospital. He gave a brief historical review of the histochemical demonstration of enzyme activity in leukocytes from the demonstration alkaline phosphtase in mature neutrophiles in 1947 to current studies utilizing acid and alkaline phosphatase and esterase. The demonstration of phosphatase in myeloid cells, of esterase in the monocytes and the absence of these enzymes in lymphocytes provides a useful tool in the chemical identification of cells which may be morphologically similar in various infectious and neoplastic diseases.

"Extensive Arterial Damage Induced in Rats by ACTH" by Drs. Benjamin Miller and Bernard Wexler of the May Institute, affiliated with the Jewish Hospital, was presented by the latter. The observations presented arose from an experiment designed to check the regenerative power of the remaining kidney in old and young rats subjected to unilateral nephrectomy.

Administration of steroids and ACTH in various combinations for 48 days after the nephrectomy produced hypertension in the older animals but not in the young rats. No gross vascular abnormalities were seen in the young rats but histologic abnormalities included perivascular accumulations of red material and some swelling of the myofibrils. Vascular changes in the older animals were extensive and included disseminated arteriosclerosis, ectasia of the aortic arch with aneurysm in the ascending segments and organizing iliac phlebothrombosis. Histologic changes included fragmentation of the myofibrils, loss of elastic fibers, medial calcification and chondroplasia, an increase in the interlamellar bridges, a swelling of the ground substances and intimal proliferation.

Dr. Boris Gueft's topic was "Abnormal Human Liver Under the Electron Microscope." The present models of the electron microscope have a maximum resolving power of 5A° and a practical resolving power of 30A° in contrast to the original design of 25 years ago which had a resolution of 0.5 micron. With a series of electron photomicrographs of abnormal human livers he illustrated various patterns of cytoplasmic and nuclear detail, and indicated areas in which the accumulated information suggested a value in differential diagnosis.

Abstracts of Cases from Slide Library

Case 627: Presented by Dr. B. S. Black-Schaffer, Cincinnati General Hospital.

A 30 year old housewife was hospitalized because of dyspnea and cyanosis. She died 15 hours later. The patient had always been in good health with normal blood pressure. Six months before entry, she awoke one morning with an aching pain in the left anterior chest and in both shoulders. She entered the hospital for study two months later. The findings at that time were an enlarged heart, a to and fro murmur over the aortic area, and a loud and snapping second pulmonic sound. Blood pressure was 150/0. There was a Corrigan pulse. Serologic tests for syphilis, L. E. preparations and blood cultures were all negative. Sedimentation rate was 32 and antistreptolysin titre 12 units. EKG showed prolonged A-V conduction and left ventricular hypertrophy. Digitalis, ACTH, and antibiotics were of little help.

Two weeks before admission, mild precordial pain and bouts of nocturnal dyspnea were experienced. On the day of admission she had right anterior lower chest pain, cough, and hemoptysis, dyspnea, and cyanosis. She was re-hospitalized and found to be cold and cyanotic. Blood pressure was 70/0. Despite supportive measures Cheyne-Stokes respiration supervened and the patient died.

Diagnosis: *Chronic nonspecific aortitis.*

Case 628: Presented by Dr. Paul Wozencraft, Cincinnati General Hospital.

A 41 year old Negro was hospitalized on September 21, 1956, because of increasing dyspnea of one year duration. At the age of 21, the patient was observed in the clinic with a penile ulcer, and later, venereal warts. He had also had gonorrhea. Serologic tests for syphilis, repeated many times, were negative. Physical exami-

nation revealed severe dyspnea. Pupils did not react to light or accommodation. Respirations were 44/m. Blood pressure varied from 180/90-40 to 215/70-0. The heart was enlarged. A loud diastolic murmur at the base was transmitted to the apex and a loud systolic murmur at the apex was transmitted to the axilla. The liver was down 3 fingerbreadths and there was edema up to the knees. Blood counts were normal. The urine showed 4 plus albumin and occasional white cells in the sediment. Serologic tests for syphilis were again negative. X-ray revealed fluid at both lung bases. The patient died two days later.

At autopsy the heart (755 grams) showed global hypertrophy and dilatation with evidence of aortic regurgitation. Coronary ostia were elevated. Three healed intimal tears were identified; one at the posterior sinus of Valsalva, and two immediately above the aortic valve. The kidneys were enlarged (right 225 grams and left 275 grams). Capsules stripped with ease and cut sections were not remarkable.

Diagnosis: *Syphilitic nephritis of Rich.*

Case 629: Presented by Dr. Herbert Braunstein, Cincinnati General Hospital.

A 4 year old white child was hospitalized because of fever, lethargy, anorexia and rash. The rash started on the face and spread to the trunk. At one year of age, the child showed definite evidence of retardation, both physical and mental. She had frequent colds and her general health was considered poor. The patient had an older sibling with cranial synostosis who was operated upon, but the outcome is not known.

Physical examination showed a girl with grotesque facial characteristics. Temperature 102°, pulse 120, and respirations 38. Supra-orbital ridges were prominent. Nasal bridge was depressed. The neck was short and thick. The liver and spleen were enlarged. There was ankylosis of the glenohumeral joint. The hands were broad and wide, and the fingers were contracted. Morbiliform rash was noted on the face and trunk. On admission, white blood count was 10,000 with 71 per cent neutrophils, 25 per cent lymphocytes and 4 per cent monocytes. Tracheotomy was carried out for respiratory distress. The patient expired the morning following entry.

Diagnosis: *Gargoylism.*

Case 630: Presented by Dr. Paul N. Jolly, Christ Hospital.

A 36 year old white woman had a radical mastectomy for carcinoma in March 1956. Metastases were present in several axillary lymph nodes. The patient became pregnant in August, and at the same time developed signs of osseous metastases in C-2, C-4 and several ribs. Increasing pain finally required hospitalization. Terminally, there were periods of coma with episodes of muscular rigidity and transient tremors. Obstructive type of jaundice was noted shortly before death in January 1957.

Metastases were identified in the lungs, liver, one adrenal and all of the retroperitoneal and mediastinal lymph nodes. The spleen weighed 400 grams and had a pale red pulp containing small, irregular, poorly defined, gray markings.

Diagnosis: *Signet ring carcinoma metastatic to spleen.*

Case 631: Presented by Dr. Benjamin Landing, Children's Hospital.

A 4 year old colored girl was brought to the hospital with hematemesis and melena. She expired the following day. The patient had been delivered spontaneously, at term, in a hospital. Jaundice, which was noted soon after birth, continued to deepen, and at age of three months she was explored. Neither gallbladder nor bile ducts were identified. No procedure was carried out. After discharge, her course was characterized by repeated upper respiratory tract infections. Clubbing of the fingers was noted at age two years. Repeated (5) hospitalizations occurred from age three years to the present admission because of hematemesis and melena. Therapy was essentially supportive.

Laboratory findings during the patient's life were as follows: thymol turbidity ranged from 11 to 39 units; total lipids, 1065-1600 mg.; serum bilirubin (direct/total), 2/12 - 13/23 mg.; alkaline phosphatase, 14-22 Bodansky units. There was a reversal of albumin/globulin ratio terminally. Hemoglobin, 4 grams per 100 ml.; hematocrit, 10. Blood pressure was 80/30. At autopsy no gallbladder nor extrahepatic bile ducts were identified. In place of the gallbladder there was a 1.5 cm. cystic structure which contained clear viscid material. The liver weighed 860 grams. It was nodular (2-5 mm.), and discolored green.

Diagnosis: *Bile duct atresia with cirrhosis.*

Case 632: Presented by Dr. William Collins, Lima, Ohio.

A 49 year old white married woman was hospitalized for repair of a cystocele and a small inguinal hernia. The patient had never menstruated or been pregnant. Several years ago, she had been told that she had no uterus. She had had normal marital relations. She had an unmarried sister who had never menstruated, and a married sister who had had menses but had never been pregnant.

Physical examination revealed a well developed, well nourished woman. Body hair was fine and scanty. There was no axillary hair and only scant pubic hair. The breasts were large, but the nipples were very small. External genitalia appeared to be that of a much younger woman. A palpable mass 4 by 3 by 2 cm. was present in the left inguinal canal.

A left herniorrhaphy was carried out, and a mass resembling testis was found attached to the lower end of the hernial sac. A laparotomy was then performed, and a similar mass was found in the right inguinal canal. No uterus, tubes or ovaries were identified.

Diagnosis: *Gonad of male pseudohermaphrodite.*

Case 633: Presented by Dr. Philip Wasserman, Jewish Hospital.

A 50 year old white woman had several hospitalizations from 1951 to her final admission in November 1956. In 1951, she had metrorrhagia. A supracervical hysterectomy without removal of adnexa was carried out for leiomyomata. Stromal endometriosis was an incidental finding in the resected uterus. Four years later, the patient had vaginal bleeding, and a 2 to 3 cm. mass was felt in the left fornix. A biopsy revealed stromal endometriosis. Radiation therapy (total dose, 1245 r) to the anterior and posterior pelvis was initiated. This resulted in reduction of the vaginal mass.

Late in 1955, she developed neck and chest pains. In addition, a pericardial rub, a grade II systolic murmur at the aortic area, and a grade III systolic murmur at the pulmonic area were heard. X-ray of the chest revealed pericardial effusion and left pleural effusion. Pelvic examination was not remarkable in November 1955. From December 1955 to November 1956 the patient was in fair condition at home. She had hot flashes and was therefore treated with estrogen. Following the estrogen therapy, she developed masses within the lower abdomen and large, purple, grape-like masses filled the vagina. Estrogen was discontinued and there was complete recession of vaginal and abdominal masses.

The final admission was for pulmonary infarction. At the same time, there was an area of absent heart pulsation at the left border of the heart. A pulmonic systolic murmur and a decreased P2 were observed. Prior to death, edema of the lower extremities and cyanosis supervened.

The section is from the heart which showed large masses of yellow-tan tissue infiltrating the myocardium and occluding the pulmonary artery at its origin.

Diagnosis: *Metastatic malignant stromal endometriosis.*

Case 634: Presented by Dr. Jan Schwarz, Jewish Hospital.

A 47 year old laborer was admitted to Hospital

Obrero, Lima, Peru, with an eight month history of repeated jacksonian seizures of the left arm and the left side of the face. Frontal headache accompanied the seizures. The frequency of these seizures increased in the two weeks prior to admission. Physical examination revealed bilateral ocular fundal edema and congestion, more marked on the right side. There was a left hemiparesis with accentuation of reflexes on the same side. A craniotomy was performed, and a 5 cm. mass was excised from the right temporal lobe. The mass was firm, with irregular areas of necrosis.

Diagnosis: *South American blastomycosis.*

Case 635: Presented by Dr. Paul Wozencraft, Cincinnati General Hospital.

In September 1956, an 18 year old girl was readmitted to the hospital with a complaint of painful swelling of the left parotid region. In 1950 she had had an excision of a mass in the same area. Diagnosis at that time is unknown, and slides from that lesion are not available. In 1954 a recurrent painful nodule in the same area was re-excised. On physical examination at the time of admission in 1956, a left submaxillary swelling was also noted. The latter mass was removed. It was nodular and firm with a smooth, lobulated cut surface and a yellowish-pink color. Sections are from the submaxillary mass, which resembles histologically the lesion removed from the parotid area in 1954.

Diagnosis: *Well-differentiated salivary gland carcinoma.*

Case 636: Presented by Dr. Boris Gueft, Veterans' Hospital, Cincinnati.

A 6 year old white boy was hospitalized with fever and vomiting of two days' duration. He was exposed to mumps two weeks prior to admission. One day before admission, he developed fever which was associated with persistent vomiting and headache. On the day of admission he became drowsy and complained of stiff neck.

Physical examination revealed nuchal rigidity, inflammation of the Stenson's duct and left parotid swelling. Deep tendon reflexes were normal. There were no abnormal reflexes. Lumbar puncture showed an initial pressure of 280. The spinal fluid contained 600 cells/cu. mm., all lymphocytes. Culture was negative. In the hospital the patient lapsed into coma and developed clonic convulsions. He regained consciousness only to develop opisthotonos, athetoid movement, and rigidity. He expired eight hours after admission.

Diagnosis: *Mumps parotitis.*

Relationship Between Blood Lipid Levels And Arteriosclerotic Heart Disease

There appeared to be no connection between actual quantitative intake of animal fats and an elevated blood cholesterol level.

The study pointed up the obvious importance of heredity as a factor, particularly when the sibling relationships were studied. The comparison of doctors with sibling histories gave the highest mean cholesterol for any familial comparison.

The study indicates that although it is disadvantageous to be overweight, the condition may not be traceable to the expected causes. It does indicate that a metabolic defect (perhaps dictated by heredity) is involved in the problem of hypercholesterolemia and possible arteriosclerotic heart disease, rather than gross dietary intake of animal fats.—David Taft, B. S., and F. C. Coleman, M. D., Des Moines: *J. Iowa M. Soc.,* 48:293, 1958.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is a summary of cases presented before the Franklin County Pelvic Cancer Delay Committee at the Tumor Conference, University Hospital, on Wednesday June 18th.

Case No. 62. The patient is a 50 year old individual who developed a sensation of constipation and fatigue six months prior to admission. One month prior to admission patient had rectal bleeding. Her family physician did a pelvic examination and found a tumor mass filling the entire pelvis. In the hospital on examination she was found to have an annular constricting lesion 6 cm. about the anus and a mass filling the pelvis. Laparotomy done. Total hysterectomy, bilateral salpingo-oophorectomy carried out. Pathology reported adenocarinoma, site unknown. Carcinoma was found to spread throughout the pelvic viscera.

Comments: (DR. HOLZAEPFEL) — No rectal biopsy was taken, nor was there any record of sigmoidoscopy. The possible origin of rectal adenocarcinoma could not be ruled out. (DR. POMEROY) — Nitrogen mustard therapy was reserved for later palliation. This patient was treated with external radiation. Regardless of the site of origin prognosis is poor. (DR. BOUTSELIS) — This patient's only opportunity for early diagnosis would have been periodic examinations including a Papanicolaou smear, pelvic examination and rectal examination. This disease process was beyond cure at the time patient was first seen.

Patient Delay: Six months.

Physician Delay: None.

Case No. 63. The patient is an 82 year old lady with previous admission to University Hospital two years prior to this admission. No rectal or pelvic examination made on previous admission. Patient transferred to nursing home. Admitted University Hospital in June with far advanced vulvar malignancy and pharyngeal malignancy with submandibular metastasis.

Institutional Delay: Two years.

Comments: (DR. POMEROY) — It is of interest to note that when this patient reported to X-Ray Department no note is recorded on the chart of any positive findings on laryngoscopy or by palpation of the throat. (DR. BOUTSELIS) — This patient had some type of vulvar lesion two years ago. At age 82 the lesion would not have spread so rapidly that there would not have been malignant or pre-malignant lesion two years ago. (DR. HOLZAEPFEL) — The fact that no pelvic or rectal examination was done on the patient on her previous hospital admission sets the delay entirely on the shoulders of the institution.

The modern treatment of hypertension is a source of hope to the hypertensive patient and of enthusiasm to the clinical investigator.—*J. Arkansas M. Soc.,* 55:31, June, 1958.

Crash Injury Project . . .

Ohio Physicians Are Asked To Cooperate in This Program Sponsored by Professional and Highway Groups and Aimed at Reducing Traffic Toll

UNDER way in Ohio is an automotive crash injury research project in which Buckeye State physicians are asked to cooperate so that information gained from the survey may help to uncover methods of reducing accident tolls.

Known as the Ohio–Cornell Automotive Crash Injury Research Project, it is being sponsored jointly by the Cornell University College of Medicine, New York; Ohio State Highway Patrol, Ohio Department of Highway Safety, Ohio Committee on Trauma (American College of Surgeons) and the Ohio State Medical Association.

The program started July 1 in a selected group of counties. After six months, it will be moved to another group of counties for a similar period, with that schedule to be followed for a three-year period. Interpretation and evaluation of the data obtained will be made at the Cornell Research Center in New York.

Auto Accidents Only

All automobile accidents involving personal injury or death that the State Highway Patrol investigates are reported. No truck, bus, motorcycle or pedestrian accidents are included. Mechanical and physical aspects of the accidents are reported by the Patrol. Medical information is reported by the physician called in on the accident.

When a physician is called in, the Patrolman investigating the accident will provide the physician with a form on which the medical information is to be recorded. The physician is to complete the form and mail it to Dr. Tom F. Lewis, Medical Coordinator, Crash Research Program, Mount Carmel Hospital, Columbus, Ohio. The investigating officer's report is mailed to Highway Patrol Headquarters in Columbus.

The medical coordinator indexes each report and forwards it to the Cornell Crash Injury Research Center, and Patrol Headquarters follows the same procedure with the investigating officer's report.

All information provided by physicians is treated as privileged medical information used only for research purposes. The medical report form contains a perforated section on which the names of physician and patient are entered. Once the research center records the report on IBM punch cards, the perforated section is torn off and destroyed. This is to preserve the anonymity of persons involved.

The program started July 1 in 16 counties, those being Hancock, Putnam, Henry, Wood, Allen, Hardin, Lorain, Medina, Summit, Ashland, Wayne, Athens, Meigs, Vinton, Hocking and Cuyahoga, excluding Cleveland.

At the 1958 Annual Meeting, the OSMA House of Delegates resolved that all Ohio physicians be urged to cooperate in the program.

President Woodhouse has sent a letter to all physicians in those counties, pointing out that "it is hoped this important project will yield a new type of information needed by engineers and safety groups who can put it to use in an attempt to solve the gigantic auto injury problem.

"Your participation is earnestly recommended by the Ohio State Medical Association's Traffic Safety Committee, which believes this is one of the finest projects set up to date to try to find the answer to the auto crash injury problem. Please cooperate." Other OSMA members will receive similar letters when the program moves into their areas.

The Cornell University Medical College has included Ohio among 16 states being studied.

Committee Named

As a result of the House of Delegates resolution, which also directed Dr. Woodhouse to appoint a special traffic safety committee of the OSMA, the President has named to the committee the following:

Dr. Nicholas J. Giannestras, Cincinnati, chairman; Dr. Lewis, Drs. Robert E. Zipf, Dayton; John F. Tillotson, Lima; F. M. Douglass, Toledo; Eldon C. Weckesser, Cleveland; John R. Willoughby, Jr., Warren; Clark M. Dougherty, New Philadelphia; Dean H. Northrup, Marietta; Charles E. Holzer, Gallipolis; Drew L. Davies, Columbus, and Lester G. Parker, Sandusky.

The first meeting of the committee was held June 15 and out of that meeting came, among other things, a request that all county medical societies establish a Committee on Traffic Safety to work in conjunction with local Citizens' Committees on Traffic Safety. The committee also voted to advise Governor O'Neill of this action.

Drs. Davies and Weckesser represented the Association at the Ohio Citizen Leadership Action Conference on traffic safety in Columbus June 24. Dr. Davies previously represented OSMA at the President's Conference on Traffic Safety in Chicago April 1 and 2.


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AMA Session in San Francisco . . .

Ten Ohioans Participate in House of Delegates; Dr. G. A. Woodhouse Reappointed to AMA Judicial Council; Review of Business Transacted

THE United Mine Workers of America Welfare and Retirement Fund, Social Security coverage for self-employed physicians, relations with voluntary health organizations, veterans' medical care, the Medicare program, the Association's Washington Office and over-all legislative system, the medical aspects of hypnosis and the advertising of over-the-counter medications were among the variety of subjects acted upon by the House of Delegates at the American Medical Association 's 107th Annual Meeting held June 23-27 in San Francisco.

Dr. Louis M. Orr, Orlando, Fla., was chosen unanimously as **president-elect** for the coming year. Dr. Orr has been vice-speaker of the House of Delegates and chairman of the AMA Committee on Federal Medical Services. He will become president of the American Medical Association at the June, 1959, meeting in Atlantic City, succeeding Dr. Gunnar Gunderson, LaCrosse, Wis., who became the 112th president at the Tuesday night inaugural ceremony.

The 1958 **Distinguished Service Award** of the American Medical Association was voted to Dr. Frank Hammond Krusen, professor of physical medicine and rehabilitation at Mayo Foundation, Rochester, Minn., for his outstanding achievements and contributions in the field of physical medicine and rehabilitation. For only the fourth and fifth times in AMA history, the House also approved special **citations to laymen** for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipients of these awards were Mrs. Charles W. Sewell of Otterbein, Indiana, who has spent 45 years in rural health work, and Gobind Behari Lal, Ph. D., distinguished science writer and Pultizer prize winner.

Ohio's Delegation

The Ohio State Medical Association was represented in the House of Delegates by: Dr. Paul A. Davis, Akron; Dr. Charles L. Hudson, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. Paul F. Orr, Perrysburg; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. Herbert B. Wright, Cleveland, and Dr. George A. Woodhouse, Pleasant Hill, chairman of the delegation. Other Ohioans in the House of Delegates were: Dr. Charles L. Leedham, Cleveland, Section on Military Medicine, and Dr. Walter J. Zeiter, Cleveland, Section on Physical Medicine.

Dr. Schriver was chairman of the Reference Committee on Executive Session. Dr. Orr was a teller.

Dr. Woodhouse was reappointed by the President to the AMA Judicial Council.

Accompanying the delegates was Mr. Charles S. Nelson, Executive Secretary, and Mr. George H. Saville, director of public relations, of the OSMA. They also attended the Conference of Medical Society Executives held in San Francisco on the eve of the AMA Session.

Representing the U. S. Public Health Service in the House of Delegates was Dr. John D. Porterfield, well known in Ohio as former director of the Department of Mental Hygiene and Correction. He is now Deputy Surgeon General of the USPHS.

On behalf of the Ohio Delegation, Dr. Sherburne introduced a resolution on the subject of Voluntary Health Insurance for the Aged. This resolution was based on the action of the OSMA House of Delegates at the Cincinnati meeting, April 14-17, 1958, in adopting Resolution No. 2, introduced by Dr. C. R. Jablonski, Cleveland.

Resolution from Ohio

Dr. Sherburne's resolution, which was referred to the Reference Committee on Insurance and Medical Service, read as follows:

"Whereas, The rising cost of living has in many cases made it extremely difficult for the aged living on pensions or other fixed incomes to meet the costs of medical care; and

"Whereas, The problem is expected to worsen due to the rising number of aged in our population and due to the constant rise in costs of living; and

"Whereas, The many attempts to solve the problem in the Congress of the United States all would open the door to socialized medicine; and

"Whereas, The House of Delegates of the Ohio State Medical Association in session on April 17, 1958, expressed the belief that voluntary health insurance programs may be in a position to assist in meeting this problem; therefore be it

Resolved, That the newly-created Joint Council

to Improve the Health Care of the Aged should take immediate steps to confer with voluntary health insuring agencies and organizations on the feasibility of offering a contract which will provide (1) medical and hospital coverage for those beyond the age of 65 and (2) a method whereby the insured may secure paid-up coverage for life through the payment of necessary premiums prior to attaining the age of 65 years."

Ohio Proposal Approved

The report of the reference committee on the resolution, which was unanimously approved by the House of Delegates, follows:

"Your reference committee is in general agreement with the intent of this resolution. It approves Section (1) of the resolution. Your committee, however, is of the opinion that the second section of the resolution concerning 'paid up coverage for life through the payment of necessary premiums prior to attaining the age of sixty-five years' may not now be considered feasible. This committee wishes to call your attention to the report of the Reference Committee on Insurance and Medical Service urging a continuation of studies along these lines which was approved by the House of Delegates at the 1957 Clinical Session. Further, your committee is of the opinion that it is inappropriate to refer resolutions from this House directly to an inter-association group such as the Joint Council to Improve the Health Care of the Aged. With these comments in mind the committee **recommends adoption of this resolution with the suggestion that it be referred to the Board of Trustees for proper implementation."**

United Mine Workers

Major discussion of relations between medicine and the UMWA Welfare and Retirement Fund centered on a reference committee report which concurred in a Board of Trustees opinion that final action on two resolutions adopted in December, 1957, should be postponed until the final report of the Commission on Medical Care Plans is received.

One of those resolutions, Number 20, declared that "a broad educational program be instituted at once by the American Medical Association to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the 'Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund' adopted by this House last June."

The other resolution, Number 24, called for the appropriate AMA committee or council to engage in conferences with third parties to develop general principles and policies which may be applied to their relationships with members of the medical profession.

In explaining its position that final action on the two resolutions should be taken only after proper study, the reference committee said it "anticipates that the final report of the Commission on Medical Care Plans will contain recommendations serving to clarify the relationships between the medical profession, the patient and third parties, and the committee has been assured that this can be expected." The committee also urged the Commission to present its recommendations no later than December, 1958.

The House of Delegates, however, by a vote of 110 to 72, adopted a floor amendment **"that this section of the Reference Committee report be amended to show that our AMA Headquarters Staff is directed, under supervision of the Board of Trustees, to proceed *immediately* with the campaign which was originally ordered at Philadelphia last December, that no further delays will be tolerated, and that the Council on Medical Service be relieved of any further responsibility in this matter."**

Social Security Coverage

In considering seven resolutions dealing with the inclusion of self-employed physicians under the Social Security Act, the House disapproved of three which called for polls or a referendum of the AMA membership, one which favored state-by-state participation in Social Security, and two which called for compulsory inclusion on a national basis.

Instead, the House adopted a resolution pointing out that "American physicians always have stood on the principle of security through personal initiative," and **reaffirming unequivocal opposition to the compulsory inclusion of self-employed physicians in the Social Security system.**

On the question of polls, the House expressed the opinion that any poll should be taken on a state-by-state basis and the results transmitted to the AMA delegates from that state. It also pointed out that since there is no provision in the Constitution and Bylaws for a referendum of members, such a referendum would usurp the duties and prerogatives of the House of Delegates, which is the Association's policy-making body.

Voluntary Health Organizations

Dealing with problems that have arisen in the raising and distributing of funds since develop-

ment of the concept of united community effort, **the House adopted the following statement** offered in the form of amendments from the floor:

"1. That the House of Delegates reiterate its commendation and approval of the principal voluntary health agencies.

"2. That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own programs of research, public and professional education and fund raising in their particular spheres of interest.

"3. That the House of Delegates respectfully requests that the American Medical Research Foundation take no action which would endanger the constructive activities of the national voluntary health agencies.

"4. That the Board of Trustees continue actively its studies of these perplexing problems looking forward to their ultimate solution."

Veterans' Medical Care

Pointing out that the Federal government spent $619,614,000 on hospitalized medical care of veterans in VA hospitals in 1957, of which about 75 per cent had non-service-connected disabilities, and that ways and means of obtaining economy in Federal government are allegedly being sought by Congress at this time, the House **urged Congressional action to restrict hospitalization of veterans at VA hospitals to those with service-connected disabilities.** It also recommended that the American Medical Association suggest to the Dean's Committees that they restrict their activities to Veterans Administration hospitals admitting only patients with service-connected disabilities.

The Medicare Program

In disapproving a resolution calling for repeal, modification or amendment of Public Law 569, the House took the position that desired changes in the Medicare program could be accomplished **through modification of the present implementing directives without the necessity for new legislation. The House reaffirmed the action taken last year in New York recommending that the decision on type of contract (service or indemnity) and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination.** Also reaffirmed was the Association's basic contention that the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

Washington Office

The House adopted a resolution requesting the Board of Trustees to make an immediate **survey and re-evaluation of "the functions and effectiveness of the over-all AMA legislative system, including the Washington Office,** in the light of present-day needs of the government, public and medical profession alike for effective liaison between government and medicine on all matters affecting the public's health and adequate, prompt and accurate transmittal to the full membership of the AMA of information on all current public issues in which the physician has a direct interest." The House asked that the Board of Trustees implement, as rapidly as possible, all changes and additions that its survey discloses are desirable to achieve the basic purpose of the resolution, "effective public and government relations."

Medical Aspects of Hypnosis

A Council on Mental Health report on "Medical Use of Hypnosis" was approved by the House, which recommended that it be published in *The Journal of the American Medical Association* with bibliography attached. The report stated that general practitioners, medical specialists and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It stressed, however, that all **those who use hypnosis need to be aware of the complex nature of the phenomena involved.** Teaching related to hypnosis should be under responsible medical or dental direction, the report emphasized, and should include the indications and limitations for its use. The report urged physicians and dentists to participate in high level research on hypnosis, and it vigorously condenmed the use of hypnosis for entertainment purposes.

Over-the-Counter Medications

The House endorsed recommendations by the Public Relations Department that:

The AMA join with other interested groups in setting up an expanded voluntary program, coordinated by the National Better Business Bureau, which will **seek to eliminate objectionable advertising of over-the-counter medicines.**

The AMA counsel with the National Better Business Bureau in the selection of a physicians' advisory committee.

The established facilities of the AMA, such as the Chemical Laboratory, the offices of the various scientific councils, and the Bureau of Investigation, be made available, so far as is feasible, to aid in the carrying out of this program.

The Public Relations Department continue its

liaison work with the various groups involved and assist in the development and operation of this program in any way possible.

The AMA become a sustaining member of the National Better Business Bureau, giving evidence of its willingness and desire to support this organization in its worthwhile activities.

Miscellaneous Actions

Actions were taken on many other subjects by the House as follows:

Adopted amendments to the **Constitution and Bylaws** which eliminate the separate offices of Secretary and Treasurer, combining them into one, and which change the titles of the General Manager and Assistant General Manager to Executive Vice-President and Assistant Executive Vice-President;

Recommended the appointment of a Committee on **Atomic Medicine** and Ionizing Radiation and suggested that it concern itself with informing the American public on all phases of radiation hazards related to the national health;

Approved in principle the admission of the **Virgin Islands Medical Society** as a constituent society of the American Medical Association;

Commended the **Federal Food and Drug Administration** for its untiring efforts in behalf of the public and the profession, and urged all states to review and strengthen their food and drug laws;

Approved the "Suggested Guides for the Organization and Operation of Medical Society **Committees on Aging,**" submitted by the Council on Medical Service;

Commended the Committee on Medical and Related Facilities of the Council on Medical Service for its report on the **Hill-Burton** Study and approved its recommendations;

Requested that any funds provided under the Public Assistance provisions of the Social Security Act for **medical care of the indigent** be administered by a voluntary agency such as Blue Shield on a cost plus basis or by a specific agency established by the medical society of the state in which indigent care is rendered;

Directed the Board of Trustees to study problems pertaining to licensure by **reciprocity** and to consult with the Federation of State Medical Boards in an attempt to find a satisfactory solution;

Urged all members of the House of Delegates to give full consideration to the preliminary report of the Committee on Preparation for **General Practice** and to submit comments and suggestions to that committee;

Expressed the opinion that some operating room experience is valuable and necessary training for all **nurses:**

Recommended that general hospitals, wherever feasible, be encouraged to permit the hospitalization of suitable **psychiatric patients,** and

Approved a **National Interprofessional Code** for physicians and attorneys prepared by the joint liaison committee of the American Medical Association and the American Bar Association.

Opening Session

At the Monday opening session Dr. David B. Allman, retiring AMA president, urged every physician to rededicate himself to the service of mankind and every medical society to strengthen its disciplinary system "to prevent the very few from besmirching the vast majority of us."

Inaugural Ceremony

Dr. Gundersen, in his inaugural address, called upon the medical profession to accept its full responsibilities in promoting better world health, brotherhood and peace, adding that "the time has come when medical statesmanship must be used to augment the methods of political diplomacy."

Election of Officers

In addition to Dr. Orr, the new president-elect, the following officers were elected by the House:

Dr. W. Linwood Ball of Richmond, Va., vice-president; Dr. E. Vincent Askey of Los Angeles, re-elected speaker, and Dr. Norman A. Welch of Boston, vice-speaker.

Dr. Warren W. Furey of Chicago was elected for a five year term on the Board of Trustees, succeeding Dr. E. S. Hamilton of Kankakee, Ill. Dr. Raymond M. McKeown of Coos Bay, Ore., was re-elected for a five year term, and Dr. R. B. Robins of Camden, Ark., was named to fill the unexpired term of Dr. F. J. L. Blasingame.

Dr. Leonard W. Larson of Bismarck, N. D., was elected chairman of the Board at its organizational meeting after the Thursday elections.

Elected to the Council on Medical Education and Hospitals were Dr. Leland S. McKittrick of Brookline, Mass., to succeed himself, and Dr. John V. Bowers of Madison, Wis., to succeed Dr. Victor Johnson of Rochester, Minn.

Dr. R. B. Chrisman, Jr., of Coral Gables, Fla., and Dr. J. F. Burton of Oklahoma City, Okla., were re-elected to the Council on Medical Service. For the same Council, Dr. Russell B. Roth of Erie, Pa., was named to fill the unexpired term of Dr. H. B. Mulholland of Charlottesville, Va., resigned.

Three members were elected to the Council on Constitution and Bylaws: Dr. William Stovall of Madison, Wis., to succeed Dr. Stanley H. Osborn

of Hartford, Conn.; Dr. William Hyland of Grand Rapids, Mich., to fill the unexpired term of Dr. Floyd S. Winslow, deceased, of Rochester, N. Y., and Dr. Walter Bornemeier of Chicago, to replace Dr. Furey.

The House approved a Board of Trustees announcement that Miami Beach will replace Chicago as the place of the 1960 Annual Meeting. Atlantic City will be the site for the 1959 session and New York the 1961 meeting. Action was postponed on selection of the city for the 1962 Annual Meeting.

Rising votes of appreciation were given to Dr. Hamilton; Dr. George F. Lull, retiring secretary, and Dr. J. J. Moore, retiring treasurer.

At the Wednesday session of the House the Illinois State Medical Society made another record state society contribution to the American Medical Education Foundation by turning over a check for $177,500 to Dr. Lull, now foundation president.

* * *

Ohioans on the AMA Program . . .

In Addition to the Official Delegation of the OSMA, Many Physicians From This State Participated in the Program or Presented Exhibits

NEARLY a hundred physicians from Ohio were listed as participants in the Scientific Program or as exhibitors at the 1958 Annual Session of the American Medical Association in San Francisco, June 23-27, according to the official program published in *The Journal of the AMA.*

Scientific Program

Dr. Carl A. Lincke, Carrollton, member of the Council on Scientific Assembly, presided over a general scientific meeting panel discussion on the management of the severely injured patient.

Dr. Robert A. Hingson, professor of anesthesiology of Western Reserve, Cleveland, participated in the foregoing panel on management of the severely injured patient, discussing "Anesthetic Aspects."

Dr. Kenneth C. McCarthy, Toledo, chairman of the Section on Anesthesiology, presented the Chairman's Address before a meeting of that section on the topic "The Problem of Cardiac Arrest."

Dr. Jay Jacoby, Columbus, participated in a discussion on "Complications of Endotracheal Intubation," before the Section on Anesthesiology on Thursday afternoon.

Dr. Donald J. Birmingham, Cincinnati, opened discussion on a paper, "Value of Patch Tests in Dermatologic Diagnosis with Special Study of Follicular Reactions," before the Section on Dermatology on Wednesday afternoon.

Drs. W. J. Kolff and W. A. Keleman, Cleveland, are co-authors of a paper, "The Present Status of the use of Artificial Kidneys in Relation to Other Methods" presented as a part of a symposium on the Clinical Application of the Artificial Kidney before the Section on Experimental Medicine and Therapeutics on Thursday morning.

Dr. Rupert B. Turnbull, Jr., of Cleveland, spoke on the topic, "Present-Day Experience with the Surgical Management of Chronic Ulcerative Colitis," before the Section on Gastroenterology and Proctology on Tuesday afternoon.

Dr. George S. Hackett, Canton, presented a paper before the Section on General Practice, Thursday morning, on the subject, "Cervical Whiplash Injury."

A team from Cleveland, Drs. Fay A. LeFevre, Alfred W. Humphries and Victor G. deWolfe, presented the subject, "The Management of Arteriosclerosis Obliterans of the Extremities," before the Section on Internal Medicine on Tuesday afternoon.

Dr. Alvin Davis, Cincinnati, participated in a panel discussion on the subject, "Noise—Is It a Health Problem?" before the Section on Laryngology, Otology and Rhinology on Wednesday morning.

Additional Speakers

Dr. Charles L. Leedham, Cleveland, in addition to being delegate of the Section, opened discussion on a paper entitled "Renal Residuals of Acute Hemorrhagic Fever — Three-to-Five-Year Follow-Up," before the Military Section.

Dr. Robert T. P. deTreville, Dayton, opened discussion on a paper entitled, "Microwave Effects—A Report on the Progress of the Air Force Program Investigating the Biological Effects of Electromagnetic Radiation," before the Section on Military Medicine on Thursday morning.

A team from Dayton—Drs. Edwin Z. Levy, G. E. Ruff, and V. H. Thaler, presented a paper before the Section on Military Medicine on Friday

morning, the title of which was "Studies in Human Isolation and Crew Confinement."

Dr. John M. Painter, Kent, spoke on the subject, "A Holistic Approach to Clinical Problems of Hypersensitivity," before a Session on Allergy on Friday morning.

Drs. James S. Krieger and Lawrence J. McCormack, Cleveland, are co-authors of a paper entitled "The Individualization of the Therapy of Carcinoma In Situ of the Cervix—A Program," presented before the Section on Obstetrics and Gynecology.

Discussions on the Eye

Dr. Donald J. Lyle, Cincinnati, opened discussion on a paper entitled "Ocular Signs and Prognosis in Subdural and Subarachnoid Bleeding in Young Children," before the Section on Ophthalmology on Tuesday afternoon.

Drs. Nick Sperelakis and Albert M. Potts, Cleveland, presented a paper entitled, "Additional Observations on Lenticular Potentials," before the Association for Research in Ophthalmology on Tuesday morning.

Drs. Albert M. Potts and Beatrice Cohen, Cleveland, are authors of a study entitled, "The Transfer of Corneal Water as Measured with the Aid of Tritium Oxide," presented before the Association for Research in Ophthalmology on Tuesday morning.

Drs. Sam G. Stubbins and W. H. McGaw, Cleveland, are co-authors of a paper on the subject, "Hanging Cast Treatment of Acromioclavicular Separations and Selected Clavicular Fractures," presented before the Section on Orthopedic Surgery on Tuesday afternoon.

Dr. Joseph E. Brown, Cleveland, opened a discussion on a paper entitled "The Orthopedic Management of Neuropathic Joints," presented before the Section on Orthopedic Surgery on Wednesday afternoon.

Dr. James I. Kendrick, Cleveland, opened discussion on a paper, "Internal Fixation of the Fibula in Fractures of Both Bones of the Leg," before the Section on Orthopedic Surgery on Thursday afternoon.

Dr. Paul A. Nelson, of Cleveland, spoke on "Physical Treatment of the Painful Arm and Shoulder," before a joint meeting of the Section on Orthopedic Surgery and the Section on Physical Medicine on Friday morning.

Dr. Ernest W. Johnson and Dr. Karl J. Olsen, Columbus, presented a discussion of the subject, "Examination for Muscle Weakness in Infants and Small Children," before the Section on Physical Medicine.

Drs. Claude S. Beck, David S. Leighninger, Jess Bond and Bernard Brofman, Cleveland, are sponsors of a paper on the subject, "Coronary Artery Disease—Some New Concepts: Results Following Surgical Operation," presented before the Section on Surgery, General and Abdominal on Thursday morning.

Dr. A. W. Humphries, of Cleveland, presided at the showing of a motion picture "Techniques of Angiography," to be shown in a repeating series Monday through Friday.

Dr. Robert S. Green, of Cincinnati, presided at the showing of a motion picture, "Cinefluorography of the Heart and Lungs.

The Scientific Exhibit

Dr. Ralph G. Carothers, Cincinnati, was chairman of the Special Exhibit on Fractures, presented in a series of demonstrations.

The following Ohio physicians participated in the Special Exhibit on Fractures as demonstrators: Drs. L. J. Cordrey, Cleveland; F. Paul Duffy, Cincinnati; R. T. Gallagher, Cincinnati; Nicholas J. Giannestras, Cincinnati, and John C. Schmerge, Cincinnati.

The following Ohio physicians participated in the Special Exhibit on Pulmonary Function as demonstrators: Drs. Frank Princi, Cincinnati; J. F. Tomashefski, Columbus; H. S. Van Ordstrand, Cleveland, and George Wright, Cleveland.

Dr. W. Clark Cooper, Cincinnati, represented the U. S. Public Health Service at the "lung station" exhibit.

Dr. J. F. Tomashefski, Columbus, was one of the demonstrators in the special "lung station" exhibit.

A team from the Ohio Tuberculosis Hospital, Ohio State University—Drs. Neil C. Andrews, A. J. Christoforidis and Philip C. Pratt, presented the exhibit, "Bronchogenic Cysts in Patients Presumed To Have Pulmonary Tuberculosis," in the Section on Diseases of the Chest.

Dr. George S. Hackett, Canton, presented the exhibit, "Occipitocervical and Low Back Pain," in the Section on General Practice.

Dr. William F. Bradley, Columbus, Central Ohio Foundation for Medical Education and Research, presented the exhibit, "Clinical Experiences with Triiodothyronine," in the Section on Internal Medicine.

Drs. Penn G. Skillern, Marvin Clamen, E. Perry McCullagh and Otto Glassner, Cleveland Clinic, Cleveland, presented the exhibit, "Radioiodine for Diagnosis and Therapy of Hyperthyroidism Due to Adenomatous Goiter," in the Section on Internal Medicine.

Dr. Curtis G. Park, Aero Medical Laboratory, Wright-Patterson Air Force Base, Dayton, pre-

sented an exhibit entitled "Men and Space," in the Section on Military Medicine.

Drs. James S. Krieger and Lawrence J. McCormack, Cleveland Clinic, presented the exhibit "Cervical Carcinoma In Situ: The Role of Radical Conization," in the Section on Obstetrics and Gynecology.

Drs. Lee J. Cordrey and James H. Christie, Highland View Hospital and Western Reserve University School of Medicine, Cleveland, presented the exhibit, "Analysis and Management of Paraosteoarthropathy in Neurologic Disease," in the section on Orthopedic Surgery.

Ohio Auxiliary a Winner In Today's Health Contest

The Woman's Auxiliary to the Ohio State Medical Association carried off one of the top honors at the Woman's Auxiliary meeting held in connection with the 1958 AMA meeting in San Francisco.

It was a winner in Group 4 (membership over 3,000) for the most subscriptions to *Today's Health.*

Among the County Auxiliary winners, the Clark County Medical Society Auxiliary took second place in Group 3 (membership from 76 to 150).

Dr. F. W. Rhinelander, Cuyahoga County Hospital and City Hospital, Cleveland, presented an exhibit, "Internal Fixation of Bone Fragments with Flexible Wire and Pins," in the section on Orthopedic Surgery.

Dr. J. W. Wilce, Ohio State University College of Medicine, Columbus, presented the exhibit, "Improved Cardiac Guidance for Sport: Backgrounds and Practical Suggestions," in the Section on Preventive Medicine.

Drs. Thomas F. Meaney and Charles R. Hughes, Cleveland Clinic, presented an exhibit entitled "Segmental Motor Paralysis: A Cause of Intestinal Obstruction and Ileostomy Disfunction," in the Section on Radiology.

Drs. William Molnar, Sidney W. Nelson, Karl P. Klassen and Joseph A. Ryan, University Hospital, Columbus, presented the exhibit "Aortic Valvulography and Ascending Aortography," in the Section on Radiology.

Drs. W. A. Hawk and A. W. Humphries, Cleveland Clinic, presented the exhibit, "Clinicopathological Observations on the Fate of Arterial Freeze-Dried Homografts," in the Section on Surgery, General and Abdominal.

Drs. Paul J. Stueber, Jr., Stevens Kovacs, Simon Koletsky, and Lester Persky, Western Reserve University School of Medicine and University Hospitals, Cleveland, presented an exhibit entitled, "Regional Renal Hypothermia," in the Section on Urology.

Dr. Raymond C. Pogge, Cincinnati, was cosponsor of an exhibit on "Medical Careers," promoted by the Medical Section of the American Drug Manufacturers Association, in the Section on Miscellaneous Topics.

Obstetricians and Gynecologists To Meet at French Lick

District V of The American College of Obstetricians and Gynecologists will meet in French Lick, Indiana on September 25, 26, and 27. The states comprising this District are: Indiana, Kentucky, Michigan, Ohio; and the Province of Ontario, Canada. Physicians of these states and province are invited to attend the scientific and social functions of the meeting. Additional information may be obtained by writing Arthur G. King, M. D., 199 William Howard Taft Road, Cincinnati 19, Ohio, District Chairman, or Sprague H. Gardiner, M. D., 23 East Ohio Street, Indianapolis 4, Indiana, general program chairman.

Registration will officially start at 8:00 a.m. Friday.

Dr. E. H. Ellison Leaves Columbus To Accept Marquette Post

Dr. Edwin H. Ellison, professor and executive officer of the Ohio State University Department of Surgery, has accepted appointment as chairman of the Department of Surgery at Marquette University School of Medicine in Milwaukee. He was a member of the Ohio State Medical Association Committee on Scientific and Educational Exhibits. He has also served as a member and chairman of the OSMA Section on Surgery.

A native of Columbus and graduate of the OSU College of Medicine, 1943, he has been associated with the college since. Dr. Ellison is author of about 50 professional papers and one surgical text. In association with Dr. Robert Zollinger, chairman of the OSU Department of Surgery, he made valuable contributions in such fields as the relationship between tumors of the pancreas and intractable ulcers, the relationship between endocrine diseases and ulcers, causes of clots in surgical patients, etc.

Dr. Ellison was named man of the year by last year's senior class at OSU and won an American College of Surgeons award for his film on a method of removing the adrenal gland.

New VA Fee Schedule . . .

Put into Effect July 1 Following Conference With OSMA Officials; Old Contract Concluded but Little Change in Standing Procedure To Occur

A NEW medical and surgical fee schedule applying to the "Home Town" Veterans Administration medical program in Ohio became effective July 1. Increases were made in 149 items.

At the same time, the formal contract between the VA and the Ohio State Medical Association which had been in effect since July 1, 1946, was concluded by mutual agreement.

From now on the OSMA will not be required to carry on any clerical or administrative duties for the VA. It will serve in an advisory capacity. Also, it will confer from time to time with VA officials regarding desirable changes in the fee schedule.

Little Change in Procedure

Physicians, as in the past, will continue to deal with the VA Regional Office, Cleveland, or the Cincinnati VA Hospital, for authorizations and payment of fees.

Recently an inquiry was sent by the VA to physicians who were listed as participants but actually did not treat any veteran patients within the last few years. This questionnaire was to establish a more realistic roster and to determine eligibility for specialistic fees.

Any licensed physician in Ohio who is not on the VA participating list may ask to become a participant by applying individually to the VA. U. S. citizenship is a requirement.

Applications from physicians in northern Ohio should be sent to the Cleveland VA Regional Office; applications from physicians in southern Ohio, to the Veterans Administration Hospital, Cincinnati, Ohio. The dividing line by counties is roughly diagonally Belmont County on the East, to Paulding County on the west. Thirty-eight counties in northern Ohio are serviced by the Cleveland regional office; 50 counties in southern Ohio, by Cincinnati VA Hospital.

Rules Reviewed

The Fee Schedule lists many items which are hospital procedures and are rarely authorized by the VA regional offices, as care in a private hospital can only be authorized if the condition is service-connected, emergent, and if it would be hazardous to move the patient to a VA Hospital. Emergencies must be reported to the VA within 72 hours.

Outpatient treatment can not be granted for non-service-connected disabilities. The only exceptions involve Spanish American War veterans and some disabled veterans receiving vocational training. Request for care on an adjunct basis can be considered.

Prior authority should be obtained before starting treatment; however, if the condition is emergent and the care is urgently needed, there is a 15 day leeway.

New Forms

All regional VA offices are now using a new authority: VA Form 10-2989b (green) for long term, and a separate VA Form 10-2989a (white) for short term authorities. Code sheets are prepared and all data for reports, professional, statistical and fiscal, are obtained from IBM cards. A separate billing is expected at the end of each calendar month on the physician's own stationery for each VA patient. Reports of treatment rendered are required monthly on all short term cases, but only quarterly in regard to long term authorities. It is hoped that the new procedures will be advantageous and time saving for the participating physicians and the VA.

Physicians who did not receive a new fee schedule from the VA and desire one should write to either the Cleveland or Cincinnati VA offices. The new fee schedule was worked out at conferences between Dr. H. P. Timberlake, chief medical officer of the Cleveland Regional Office, and officials of the Ohio State Medical Association.

Some New Fees Listed

It would not be practical for *The Journal* to publish the entire new fee schedule. Following are a few items, picked at random from the fee schedule, exclusive of major surgical fees inasmuch as most of the VA surgery is done in VA hospitals:

Visits and Examinations

0005—Complete general routine physical examination including routine urinalysis (chemical)—this item may be authorized for first office visit or first home visit when applicable $10.00

0010—Detention with patient in critical condition at home or hospital, per hour (day 8 a.m. to 7 p.m.) 10.00

(Continued on Page 1074)

0015—Detention with patient in critical condition at home or hospital, per hour (night 7 p.m. to 8 a.m.) 15.00

0020—Examination to determine need for aid and attendance, in home 8.50

0025—Examination to determine need for aid and attendance, in office 7.50

0030—Examination to determine need for hospitalization, in home (day 8 a.m. to 7 p.m.) 5.00

0035—Examination to determine need of hospitalization, in home (night 7 p.m. to 8 a.m.) 8.00

0040—Examination to determine need of hospitalization, in office 4.00

0045—Home visit (day 8 a.m. to 7 p.m.) 5.00

0050—Home visit (night 7 p.m. to 8 a.m.) 8.00

0055—Hospital visit (day 8 a.m. to 7 p.m.) 5.00

0060—Hospital visit (night 7 p.m. to 8 a.m.) 8.00

0065—Mileage one way for day or night visit outside city limits (in addition to appropriate fee) ..... .75

0070—Office visit 4.00

Examinations by Specialists

0090—Cardiac examination including electrocardiogram 15.00

0095—Dermatological 10.00

0100—Ear examination with audiogram and interpretation 15.00

0115—Electrocardiogram with interpretation 10.00

0120—Electroencephalography with interpretation 25.00

0125—Examination of ears, nose and throat 7.50

0130—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, as well as a report of abnormalities found 15.00

0135—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, together with a report of the *visual field* findings (the latter by chart if the field is abnormal) 20.00

0180—Orthopedic 10.00

0185—Physical examination of lungs 10.00

Outpatient Treatment by Specialists

0200—Dermatological: First visit or home visit 7.00

0205—Dermatological: Each subsequent office visit 5.00

0210—Ear, nose and throat: First visit or home visit 7.00

0215—Ear, nose and throat: Each subsequent office visit 5.00

0220—Neurologic treatment 10.00

0225—Ophthalmological: First visit or home visit 7.00

0230—Ophthalmological: Each subsequent office visit 5.00

0235—Psychiatric treatment, one half-hour or less 7.50

0240—Psychiatric treatment, period longer than one half-hour 15.00

0245—Other comparable specialities not listed above:
First visit or home visit 7.00

0250—Other comparable specialities not listed above:
Each subsequent office visit 5.00

Physical Therapy

0325—Any combination of treatment to one extremity or back 3.50

0330—Any combination of treatment to two or more extremities and back 5.00

0335—Physical therapy treatment in home 5.00

Other Medical Services

0705—Injections: Subcutaneous, intramuscular or intravenous exclusive of cost of drug, biological or other medication 3.50

0707—Injection of joint, exclusive of cost of drug or other medication 6.00

0730—Nonsurgical drainage of gallbladder 10.00

1475—Varicose veins, injection 5.00

1735—Urethral dilation 10.00

2425—Corneal ulcer, cauterization 5.00

2515—Lacrymal duct, dilatation of 5.00

2885—Dislocation, shoulder, recurrent or habitual, reduction only .....10-15 AA

3315—Sequestrum, removal of (superficial) .....15-50 AA

3435—Paracentesis, tympanum 10.00

3515—Proctoscopy 10.00

3520—Sigmoidoscopy 10.00

3695—Pneumoperitoneum, artificial, refill 10.00

3705—Pneumothorax, artificial, refill with fluoroscopy 10.00
3800—Cyst, superficial, aspiration 10.00
3805—Tumor, superficial—fulguration or electrocoagulation 10.00

Removal, Excision, Resection

3820—Abscess .....5-100 AA
3825—Cyst or tumor, small, benign 50.00
3835—Cyst, sebaceous .....10-25 AA
3860—Papilloma, external 10.00

Unclassified

3900—Adenectomy, cervical or inguinal 15-150 AA
3905—Carbuncle .....25-50 AA
3910—Cellulitis 25.00
3920—Ingrown toenail 15.00
3950—Foreign body removal .....10-50 AA

Radiology

4000—Abdomen (KUB) 10.00
4005—Colon, barium enema 20.00
4020—Gallbladder, Graham technique 20.00
4025—Gastrointestinal, including barium meal and enema, X-ray and fluoroscopy with preliminary KUB film 35.00
4030—Pyelography, intravenous, including cost of dye 20.00
4215—Chest, AP and lateral 10.00
4225—Fluoroscopy when required without film 5.00
4230—Fluoroscopy when required in connection with a general examination 2.50
4435—Spine, entire 35.00
4700—Deep X-ray therapy per treatment, one field 10.00
4705—Deep X-ray therapy per treatment, two or more fields 20.00
4720—Superficial therapy, benign lesion, per treatment, one to three fields 5.00
4725—Superficial therapy, benign lesion, per treatment, more than three fields 10.00
4730—Superficial therapy for skin cancer, per treatment 15.00
4735—Superficial therapy for skin cancer, maximum fee for series 50.00

Pathology

5240—Blood platelet count 3.00
5255—Bromsulfalein test 4.00
5285—Coagulation time 1.00
5290—Complement-fixation tests for syphilis 3.50
5300—Dextrose 3.00
5305—Differential leucocyte count 2.00
5315—Estimation of sugar tolerance 10.00
5355—Nonprotein nitrogen 3.00
5380—Red, white and differential blood counts including instrumental colorimetric hemoglobin estimation 5.00
5390—Sedimentation rate 2.00
5410—Total erythrocyte count 2.00
5415—Total leucocyte count 2.00
5430—Urea nitrogen 3.00
5950—Urinalysis, routine chemical 1.00
5955—Urinalysis, routine chemical and microscopic 2.00

The designation "AA" represents a range of fees for a specific procedure. The proper fee for "AA" procedures will be determined in the exercise of sound professional judgment by arbitration and agreement between VA officials authorized to approve fees and the physician rendering the service.

Cleveland and Dayton Medical Societies Increase Their Executive Staffs

Two of Ohio's County Medical Societies have added associate or assistant executive secretaries to their staffs.

Mr. Kenneth C. Evans is the new associate executive secretary of the Montgomery County Medical Society. He is working with the executive secretary, Mr. Robert F. Freeman, in administration of the Society affairs as well as those of affiliated and allied organizations. These organizations, management of which the Society council has delegated to the staff include the MCMS Telephone Service, the Medical Foundation, Inc., the Central Homograft Unit, Inc., and the Bureau of Medical Economics, Inc. The staff also has responsibilities in regard to the local cancer control society and the local heart association.

Mr. Evans came to the Society after four years as business manager of the Westminster Presbyterian Church. Prior to that he was with the Frigidaire Expense Control Section. He received his training in business administration at Ohio State and served as captain in the Army during World War II.

The new assistant executive secretary for the Academy of Medicine of Cleveland and Cuyahoga County is Mr. Donald W. Mortimer. He will work with Executive Secretary Robert A. Lang in the administrative responsibilities of the Academy and its affiliate programs.

Mr. Mortimer is a graduate of Allegheny College, Meadville, Pa., and has recently earned a master's degree. For four years before accepting the Academy post he was assistant to the dean of Cleveland College of Western Reserve University and prior to that worked with the Warner & Swasey Executive Development Program. During World War II he served with the U. S. Air Force.

Are You Eligible To Vote? . . .

Between Now and September 24 Is the Time To Register for Those Who Want to Become Eligible To Vote in the November 4 General Election

IN the busy life of a physician and members of his family time passes quickly. The all-important General Election is November 4. An equally important date for those who must register before they can vote is September 24—last day to register.

Registration is a simple matter. Here are the points to be remembered, presented in question and answer form from information furnished *The Journal* by Secretary of State Ted W. Brown:

What is the registration deadline?

Forty days before the General Election, or September 24.

Who must register?

Every citizen who resides in a "registration district" must be registered with his county Board of Elections before he is eligible to vote.

What is a registration district?

The county Board of Elections must maintain a registration of eligible voters in every city of 16,000 population or over. Municipalities of less than 16,000 population may elect to maintain registration. The Board of Elections of a county may require registration in the entire county or in certain precincts. A registration district, therefore, may be a county, a municipality, a group of precincts or a single precinct.

How does a person know whether he is in a registration district or in a non-registration area?

If he resides in a municipality of 16,000 population or over, he must be registered. If he resides in a suburban community, a small municipality or a rural area, and is in doubt, he should phone the county Board of Elections and ask.

Under what conditions must a person re-register?

Registration is permanent, subject to the following exceptions:

a. If the citizen has not voted in a general, primary or special election since January 1, 1956, he must register again.

b. If the citizen has changed name—e. g., if a woman has married—she must re-register. If a woman marries between September 24 and November 4 she may vote on November 4 under her former name.

c. A veteran of the armed services must register after he is discharged.

d. A voter who changes his place of residence from one county to another, must register with the Board in the county to which he moves if his new residence is in a registration precinct. A voter who changes his residence to a new address within a registration district must notify his Board of Elections of such change. Some boards require the voter to present himself in person; others accept written notice.

What is the procedure for voters in non-registration areas?

In precincts not in registration districts, citizens are automatically eligible to vote. A voter may be required at the polling booth to produce evidence to the satisfaction of the election judge, or under oath, that he is qualified to vote.

What is the residence requirement for registration?

A person who will have met the residence requirement for voting by November 4—that is, will have lived in the State one year, in the county and precinct 40 days, and is otherwise qualified to vote —may register on or before September 24.

If he has moved his residence between September 24 and Election Day, what can he do?

Vote at the precinct from which he moved.

If a citizen has moved or is planning to move prior to September 24, may he vote at the precinct in which he formerly resided?

No. If he does not qualify himself to vote in the new precinct by notifying the Board of change of address, he will have lost his privilege of voting on November 4.

Suppose he moves his residence on September 23?

He will have been in the new precinct for 40 days by Election Day and, therefore, may register immediately.

If a citizen in a registration district will reach his 21st birthday between September 24 and November 4, may he register?

Yes. He may register on or before September 24.

If a person who resides in a non-registration

area will be 21 years old on or before November 4, what is the procedure?

If he meets other requirements of a voter, he will automatically become eligible to vote.

Where does one register?

At the headquarters of the Board of Elections of county of residence or at polling places indicated by the Board.

Where does a student register?

Ordinarily in the county in which he maintained residence just prior to entering the institution of learning.

How does a disabled person register?

A voter who is prevented by sickness or physical disability from registering in person may apply to his county Board of Elections by mail or phone for registration forms. The application must state the facts as to the voter's disability. Both the registration forms and a declaration of the facts as to disability must be notarized, and both must be delivered to the Board of Elections by a reliable and responsible person. Some boards require this person to be a notary public.

What about persons in the armed forces?

Persons who are residents of a registration district and who are in active service in the armed forces, and are otherwise qualified to vote, may cast absentee ballots without previous registration.

Does this privilege extend to civilians who will be away from home on November 4?

No. Students and other persons who must be registered in order to vote and who plan to be away on November 4, should register now so that they will be eligible to cast absentee ballots.

ABSENTEE VOTING

Persons who will be away from home on November 4 should plan to cast absentee votes. Here are some dates to remember and other data on absentee voting:

Civilians who wish to cast absentee ballots must be qualified to vote the same as though they were voting at home; e. g., they must be registered if they live within a registration area.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail ballots which are to be properly filled out and returned in accompanying "identification" envelopes.

Ohioans who will be more than 10 miles from their polling places and outside their home counties on election day are eligible for absentee voter ballots.

September 5—First day for civilians outside the continental limits of the United States, such as wives of military men, to apply for absent voter ballots.

September 24—Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

October 5—First day for absent and disabled voters within the United States to apply for ballots.

October 30—Last day for "absent or disabled" civilians to apply. The deadline is 4 p. m.

October 31—Last day for civilians to return voted ballots to election boards to have them count. The deadline is noon of that day. Military personnel have until noon of election day, November 4.

November 1—Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.

Industrial Medical Program To Be Conducted in Akron, Sept. 19

The Industrial Medical Association of Pittsburgh, a component society of The Industrial Medical Association, will present a program on Friday, September 19 at the Sheraton Hotel, in Akron.

9:00 A. M.—Registration—*Promptor Finis Fui.*

9:30—Greetings by Dr. Arthur Dobkin, president of the Summit County Medical Society. Remarks by Dr. Don A. Kelly, Cleveland, president of the Industrial Medical Association of Pittsburgh.

9:45—**The Use of the Artificial Kidney in Poison Cases,** Dr. Walter A. Keitzer, Akron.

10:15—**Lung Surgery as Related to Occupational Conditions,** Dr. William H. Falor, Akron.

10:45—Recess.

11:00—**Reconstructive Surgery in Industry,** Dr. E. J. Kraker, Akron.

11:30—**Rehabilitation of Industrial Workers,** Dr. K. C. Keeler, Akron.

12:00 M—Luncheon and showing of the film, "Medicine in the Tropics."

1:30 P. M.—**Panel,** Moderator, Dr. Paul A. Davis, Akron.

1. **Health Hazards in the Rubber Industry, Yesterday and Today,** Dr. Warren L. Hogue, Jr., Akron.
2. **Toxicology of Materials Used in the Rubber Industry,** Dr. Rex H. Wilson, Akron.
3. **Relationship of Industrial and Private Practice,** Dr. L. C. Hatch, Akron.

3:40—Business Meeting.

4:00—Cocktail Party.

Medical Board Examinations . . .

Total of 417 Graduates of Schools of Medicine Apply for Licenses in State; List of Questions Is Given; Limited Practitioners Also Apply

THE State Medical Board of Ohio examined 417 graduates of schools of medicine who are seeking licenses to practice in the state during its examinations in Columbus June 19-21, Dr. H. M. Platter, Board secretary, reported. The board also examined 50 graduates of osteopathic schools who are seeking to practice osteopathic medicine and surgery in Ohio.

In the limited practice fields the board examined the following numbers of persons: Chiropody, 17; mechanotherapists, 10; chiropractors, 44; masseurs, 21; cosmetic therapists, 4.

Results of the examinations will be announced following a meeting of the board on August 18.

Following are the examination questions given to doctors of medicine:

Anatomy

1. In words, or by diagram (labelled), give a description of a hair follicle.
2. Name the muscles of the orbit.
3. Locate the following: (a) bregma, (b) glabella. (c) nasion, (d) inion, (e) lambda.
4. Describe an eustachian tube.
5. Give a description of the arterial and venous circulation of the kidney.
6. Enumerate the divisions of the large intestine, stating approximate length of each portion.
7. In doing a tracheotomy, what structures are involved?
8. Describe the thoracic duct.
9. Name the ligaments of the ankle joint, giving function of each.
10. Describe the prostate gland and its anatomical relationships.

Physiology

1. Name and describe briefly the several retinal functions upon which the acuteness of vision depends.
2. Discuss briefly olfaction as to: (a) Location of olfactory area; (b) As to the nature of the olfactory stimulus.
3. Discuss histamine as to: (a) its concentration in human blood; (b) its effect on human blood vessels; (c) on blood pressure; (d) on gastric juice.
4. Explain the morning alkaline tide of the urine.
5. Name and discuss briefly the placental hormones.
6. Explain the physiology of cardiospasm.
7. Explain the physiology of motion sickness.
8. Discuss briefly the mechanism of the action of insulin on: (a) Glycogen storage; (b) Fat metabolism; (c) Protein metabolism; (d) Oxidation of sugar.
9. Discuss the physiology of hypoglycemia.
10. Discuss extrasystoles as to: (a) Ventricular, (b) Auricular, (c) Nodal.

Bacteriology

1. In a patient with negative history and physical findings, what is the significance of a weakly reactive sero-diagnostic test for syphilis, and how would you proceed?
2. Discuss the significance of pathogenic staphylococci in the feces.
3. Discuss the significance of coliform bacteria in water.
4. How would you proceed in attempting to identify the cause of a virus infection?
5. In what areas and under what circumstances is moniliasis apt to occur?

Diagnosis

1. List five cardinal diagnostic findings which suggest a diagnosis of Multiple Myeloma.
2. Differentiate "Mediterranean Anemia" from: (a) Gauchers Disease; (b) Niemann-Pick Disease; (c) Schuller-Christian's Syndrome.
3. Differentiate Celiac Disease and Tropical Sprue.
4. In general terms, the urinary and blood findings or changes of acute nephrosis are similar to those observed in acute glomerulonephritis except that:
   (a) Hematuria is less frequent: —Yes. —No.
   (b) Albuminuria is more marked: —Yes. —No.
   (c) Hypoproteinemia with consequent edema is more pronounced: —Yes. —No.
   (d) Nitrogen retention is less severe or entirely absent: —Yes. —No.
   (e) Reduction in blood calcium is less marked: —Yes. —No.
5. A male patient of 35 years of age reveals a history of shortness of breath, edema or swelling of the ankles. Physical examination reveals the following:
   1. Harsh systolic murmur. Best heard at the second or third left intercostal space.
   2. Also, the murmur is heard in the left clavicular region.
   3. A palpable systolic thrill in the second or third left interspace.
   4. A decrease in the intensity of the second heart sound at the pulmonic area.
   5. X-ray findings reveal a heart within normal limits of size.
   6. Electrocardiogram reveals right ventricular strain pattern. The P waves are large with abnormally pointed peaks.
   7. Cardiac catheterization reveals an increase in systolic pressure recorded as the catheter is withdrawn from the pulmonary artery into the right ventricle.

   The diagnosis of the impairment is:
   (a) Left ventricular failure: —Yes. —No.
   (b) Rheumatic Valvulitis: —Yes. —No.
   (c) Tetralogy of Fallot: —Yes. —No.
   (d) Congenital Septal Defect: —Yes. —No.
   (e) Pulmonary stenosis: —Yes. —No.
6. Differentiate on basis of symptoms: (a) Cholelithiasis, (b) Nephrolithiasis, (c) Appendicitis, (d) Peptic Ulcer, (e) Coronary Thrombosis (Myocardial infarction).
7. Differentiate between carbon monoxide poisoning and carbon tetrachloride poisoning on basis of symptoms and findings.
8. Name three diagnostic factors that differentiate Weil's Disease from acute pyogenic and viral infections.
9. In every obscure infection in which there is enlargement of the lymph nodes with or without ac-

companying enlargement of the liver and spleen, one should suspect:
(a) Tularemia: —Yes. —No.
(b) Brucellosis: —Yes. —No.
(c) Histoplasmosis: —Yes. —No.
(d) Typhoid Fever: —Yes. —No.
(e) Mononucleosis: —Yes. —No.

10. Name one characteristic diagnostic procedure which will differentially diagnose: (a) Tularemia, (b) Brucellosis, (c) Histoplasmosis, (d) Typhoid Fever, (e) Mononucleosis.

Chemistry

1. Outline the indications for gastric analysis. In what way is it valuable as a screening diagnostic procedure?
2. Give the normal range of serum albumin concentration (plasma). Give the range found in: (a) Nephrotic syndrome; (b) Advanced cirrhosis.
3. Discuss the metabolism of Bilirubin. Discuss the Van Den Bergh reaction for Bilirubin.
4. Outline the means by which glucose is removed from the circulating blood.
5. Discuss amino acids. Where are they found? What are essential amino acids and state why they are essential.

Materia Medica and Therapeutics

1. Give the duties of the physician in case of poisoning.
2. Compare the effects of cortisone and corticotropin on the adrenal cortex.
3. Give the mechanisms of action of the anti-thyroid (goitrogenic) drugs.
4. Give the treatment of hypertonicity of body fluids caused from: (a) Solute loading; (b) Desiccation or true hydration.
5. Give the action of morphine 10 mg. (1/6 Grain) upon the central nervous system.
(b) Give the fate of morphine in the body.
6. Make a table contrasting the action of digitalis and quinidine upon tonus, contraction, refractory phase, conduction and volume output of the heart.
7. Give the onset, peak action and duration of soluble unmodified insulin, globin, isophane and protamine zinc insulin.
8. Give the treatment of hemorrhage from Bishydroxy coumarin (dicumarol).
9. Outline treatment of delirium tremens.
10. Give the treatment of diphtheria.

Practice

1. Define Erythremia (Polycythemia rubra).
(a) Give three symptoms.
(b) Name five objective findings other than the blood count.
(c) Give the blood findings: (1) Red blood count; (2) Leucocyte count; (3) Platelet count; (4) Bleeding time and coagulation time; (5) Hemoglobin determination.
2. What is the treatment of choice in managing a case of erythremia (Polycythemia vera or Polycythemia rubra)?
3. Define Diphtheria (giving etiology). (a) Give the treatment, and (b) Prophylaxis; (c) Complications.
4. What is the etiology of syphilis? (a) Mode of transmission; (b) Give briefly the treatment.
5. What is meant by the term "Collagen Disease"? Name three collagen diseases.
6. Differentiate between (a) Heat exhaustion; (b) Heat stroke; (c) Heat cramps.
(a) Elicit the treatment for each.
(b) Prophylaxis.
7. Enumerate five objective findings in Thyrotoxicosis (Hyperthyroidism). (a) Describe the treatment.
8. Differentiate between Diverticulosis and Diverticulitis. (a) What is the treatment of diverticulitis?
9. Define Hydronephrosis. (a) Etiology, (b) Treatment.
10. Give the etiological agent or agents in Epidemic Pleurodynia. (a) Elicit the important clinical manifestations; (b) Name the most frequent complication; (c) Treatment.

Pathology

1. The patient is a 45 year old white male with history, physical findings and x-ray evidence suggesting a lesion causing bronchial obstruction near the hilus of the right lung. List in the order of probability, five possible types of lesion. In a parallel column, list such helpful or substantiating laboratory examinations as may be available.
2. The patient is a 55 year old white male with history and physical findings suggesting pericarditis. List in the order of probability five possible causes. In a parallel column, list such helpful or substantiating laboratory examinations as may be available.
3. List five sites at which peptic ulceration may occur in the gastro-intestinal tract. In a parallel column, list the causative factor or factors. Describe the microscopic appearance of a typical peptic ulcer.
4. Name two renal lesions which are limited largely to diabetics. List the outstanding clinical and laboratory features of each. Briefly describe each microscopically.
5. Which testicular tumor (a) Is composed of large sheets of uniform appearing cells with little stroma and no particular grouping? (b) Most often gives a positive A. Z. or Friedman test? (c) Has the poorest prognosis? (d) Has the best prognosis? (e) Is the most common?
6. What is the significance of a positive report on a cervical cytology specimen and how should the patient be managed?
7. List in the order of probability five possible causes of disseminated osteolytic lesions in a 50 year old female. In a parallel column, list helpful laboratory examinations and their characteristic findings.
8. In a 20 year old patient with signs of meningeal irritation and the following spinal fluid findings, list in the order of probability five possible causes, and in a parallel column list helpful or confirmatory laboratory tests: Pressure, slightly increased; Appearance, clear; Clot, none; Protein, 100 mgm. per 100 cc.; Cells, 400 Cu. mm., 90% lymphocytes; Sugar, 40 mgm. per 100 cc.; Chloride, 600 mgm. per 100 cc.; Gold curve, 0002321000.
9. In a 60 year old white male with Hb. 7.7 gm. per 100 cc., RBC 2,000,000 per cu. mm., packed cell volume 23%, WBC 4200, neutrophiles 50%, lymphocytes 45%, monocytes 3%, eosinophiles 2%, platelets 110,000; what disease or diseases would you suspect and what other diagnostic procedures would you suggest?
10. In a 35 year old female with symptoms and signs of hyperthyroidism: (a) Give brief gross and microscopic description of the thyroid gland. (b) Give the typical values for basal metabolic rate, protein bound iodine, radioactive iodine uptake, cholesterol, and glucose tolerance.

Surgery

1. Define: (a) euthyroidism; (b) Hypothyroidism; (c) hyperthyroidism. Discuss each briefly from the standpoint of: (a) palpable findings; (b) laboratory findings.
2. Give the possible causes of the "dumping syndrome" in the post-gastrectomized patient, and indicate diagnostic data and corrective measures.
3. Discuss "cord bladder" as regards diagnosis and treatment.
4. Discuss diagnosis and treatment of carcinoma of the left colon and differentiate it from similar pathology in the right colon.
5. How would you treat: (a) Post-operative acute

pancreatitis; (b) Post-operative acute urinary retention; (c) Post-operative paralytic ileus; (d) Post-operative diarrhea due to antibiotic therapy; (e) Post-operative parotitis.

6. Define intussusception. What is the most frequent cause in childhood? In the adult?
7. How would you manage a case of intestinal obstruction, giving your clinical diagnostic, laboratory, and treatment approaches. A list without lengthy discussion should be used.
8. Describe the so-called "whip-lash" injury of the neck, indicating the mechanics of the injury, the treatment, and the prognosis.
9. Give a concise, but descriptive differential diagnosis in a case of right lower quadrant abdominal pain.
10. Given a palpable mass or fullness in the left upper quadrant of the abdomen, outline the differential diagnosis, and include diagnostic procedures.

Obstetrics and Gynecology

1. Give the indications and contraindications for treatment of uterine leiomyomata (fibroids) by: (a) Myomectomy; (b) Supracervical hysterectomy; (c) Total hysterectomy; (d) Irradiation therapy (x-ray or radium).
2. Briefly discuss the diagnosis, prognosis, and treatment of epidermoid (squamous cell) carcinoma of the cervix. (So-called stage 0 or carcinoma-in-situ).
3. Give the management and treatment of post-menopausal bleeding.
4. What is the significance of slight bleeding of short duration occurring regularly at midpoint of an otherwise normal average 28 day menstrual cycle?
5. Describe endometriosis and give symptoms which accompany it. What is the treatment?
6. How is the diagnosis made of fetal death in early pregnancy? In late pregnancy? Indicate treatment in each case.
7. Define placenta praevia. What is the main symptom of this and why does it not appear in most patients until the last trimester of pregnancy?
8. What signs and symptoms observed in a pregnant woman are indicative of toxemia of pregnancy? Outline management and differentiate from a case of essential hypertension.
9. What are the causes of habitual abortion?
10. Why is breech delivery hazardous for both the mother and the infant?

Specialties

1. Draw the normal visual form field for the right eye when taken with a 10 mm. white test object at 1/3 meter distance and locate the physiological blind spot.
2. Describe the visual field findings in the case of a man 62 years of age who has well advanced, bilateral, chronic, simple, wide angle glaucoma with normal central vision for distance.
3. A mother brings a 7 year old boy to your office with the history that she has received a notice from the school that he has bilateral defective hearing. What examination would you make and what would you look for and what advice would you give the mother?
4. Name five common diseases which may cause generalized pigmentation of the skin.
5. Classify tumors of the testis. What is the most common form of testicular tumor and what is its management?

Preventive Medicine and Hygiene

1. Discuss from the view point of public health, the cause and prevention of goitre.
2. When is inoculation against typhoid fever advisable? How soon would treatment become effective? What degree of protection may be expected? How long will the inoculation be effective?
3. What measures are desirable and practical for the prevention of the dissemination of disease by food handlers?

4 and 5. (Use one sheet of paper for this answer). In "Civil Defense" there has been a catastrophe in a nearby city and many residents become evacuees. Your area is designated for reception of these evacuees. Draw a plan sketch for an area on a water course for such a camp, showing water course, direction of flow, access roads, land slope, drainage, natural advantages, location of facilities, necessary shelter, provision for housing (tents or barracks), feeding, handling of persons sent to the camp, sanitary arrangements and lay-out of grounds. Label on the plan each item so that others may understand how to proceed with building and installation.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

April 1, 1958—August Robert Bauer, Jr., Columbus, University of Michigan; Danute G. Bieliauskas, Cincinnati, University of Leipsic, Germany; Ying-Chei Chen, Cleveland, National Sun Yat-Sen Medical School, China;

Alexander McGill Duff, Jr., Mansfield, Johns Hopkins University; Robert C. Lam, Peiping Union Medical College; Jane Mutuzel, University of Latvia; Gunars Medins, Akron, University of Marburg, Germany;

Leszek Ochota, Cambridge, University of Zurich, Switzerland; Zabih Sadighian, Teheran University, Iran; Nicholas Vasilkovs, Dayton, University of Wurzburg, Germany.

June 19, 1958—Robert Cain Atkinson, Columbus, Univ. of Tennessee; George Pickering Balz, Cincinnati, Univ. of Illinois; David Barr, Cleveland, Cornell Univ.; Fred "G" Blum, Jr., George Washington Univ.;

Clifford Richard Boeckman, Akron, Marquette Univ.; Richard John Bonistalli, Marquette Univ.; Warren Edgar Bontrager, Akron, Univ. of Michigan; Joseph Franklin Boyd, Jr., Toledo, Meharry Medical College; Raymond Richard Buganski, Toledo, St. Louis Univ.; Alfred Peter Bukeavich, Findlay, Univ. of Pennsylvania; Jack Mehl Burnett, St. Clairsville, Johns Hopkins Univ.;

David Michael Carberry, Akron, Jefferson Medical College; William Thomas Carter, Columbus, Univ. of Virginia; Albert Charles Casabona, Jr., Cleveland, Univ. of Pittsburgh; Louis Justin Cherry, Marion, Univ. of Pittsburgh; Thomas Christie, Univ. of Glasgow, Scotland; Roy Henry

Clauss, Cincinnati, Northwestern Univ.; Henry Frank Dale, Univ. of Berlin, Germany;

Geary Malvin Eicher, Jr., Steubenville, Univ. of Pittsburgh; Henry Steven Ellison, Youngstown, Howard Univ.; Henry Theador Forsyth, Toledo, Univ. of Michigan; Martha Neal Franz, Dayton, Indiana Univ.; Marcus Ronald Gilliss, Cleveland, George Washington Univ.; Thomas Millard Hamilton, Gallipolis, Columbia Univ.; Jesse Doddridge Hayes, Jr., Dayton, Indiana Univ.;

William Joseph Hockett, Jr., Bowling Green, Loyola Univ.; Allen Howard Holt, Youngstown, Syracuse Univ.; Harold Byron Houser, Cleveland, Indiana Univ.; Robert John Hritzo, Youngstown, St. Louis Univ.; Galen Carl Huffman, Columbus, Indiana Univ.; Richard Edward Hurley, Cleveland, Univ. of Utah;

Roger Woodham Jelliffe, Cleveland, Columbia Univ.; Allan MacKenzie Johnstone, Tulane Univ.; Lotus Morris Jones, Cleveland, Meharry Medical College;

Kenneth Leroy Kaminski, Cleveland, Georgetown Univ.; Frederick Maurice Kapetansky, Columbus, Univ. of Michigan; Ralph Katz, Cleveland, Univ. of Basel, Switzerland; William Eugene Kincaid, Cleveland, Medical College of Virginia; William Wolfgang Koslow, Univ. of Basel, Switzerland; Francis Eugene Kulcsar, Portsmouth, Univ. of Debrecen, Hungary;

Wilhelmina Lendl, Univ. of Berlin, Germany; Sidney Issaac Lerner, Columbus, Univ. of Maryland; Ira Mortimer Levy, Cleveland, Univ. of Texas; Hughie L. Lindsey, Canton, Howard Univ.; Winifred Liu, Warren, National Hsiang Ya Medical College, China; William Gideon Lockhart, Cleveland, Univ. of Arkansas;

Douglas W. Macdonald, Cleveland, Univ. of Ottawa, Ontario, Canada; Joseph John Maher, Cleveland, Georgetown Univ.; Walter Hugh Maloney, Cleveland, Temple Univ.; Walter D. Mazzacane, Royal University of Naples, Italy; Roy Lewis McKittrick, Cleveland, Columbia Univ.; Michael Vincent Miklos, Cleveland, Univ. of Pittsburgh; Charles Edward Miller, Columbus, Vanderbilt Univ.; Harry Robert Miller, Toledo, Indiana University; Margaret Bowers Miller, Toledo, Indiana Univ.; John Richard Mollenkopf, Cleveland, Stanford Univ.; Walter Alexander Murray, Jr., Columbus, Cornell Univ.; Guy Reed Musser, Warren, Jefferson Med. College;

James Stephen New, Zanesville, Univ. of Georgia; Charles Donald Noonan, Cincinnati, Univ. of California; Rudolf Reuven Oestreicher, Univ. of Prague; John Francis O'Neill, Cincinnati, Georgetown Univ.; Charles Roger Oppegard, Cincinnati, Univ. of Maryland;

Boyd Nelson Park, Cleveland, Temple Univ.; Charles Nathan Patton, Akron, Univ. of Illinois; Paul Earl Peckham, Cincinnati, Johns Hopkins Univ.; John J. Pelosi, Toledo, Georgetown Univ.; Robert Louis Perkins, Mt Vernon, Johns Hopkins Univ.; Nelson Glasgow Richards, Cleveland, Univ. of Virginia;

Herbert Henry Schneider, Univ. of Bern, Switzerland; Francis Joseph Seiler, Dayton, St. Louis Univ.; Leroy Shear, Cleveland, Univ. of Maryland; Eugene Sherman, Mansfield, Chicago Medical School; Albert Sion, Warren, University of Antioquia, Columbia, South America;

Howard H. Smead, Lorain, State Univ. of Iowa; Blanca Smith, Columbus, Nat. Univ. of Brazil, S. America; Robert L. Smithwood, Worthington, Indiana Univ.; J. Clyde Spencer, Jr., Univ. of Michigan;

Joseph William Tandatnick, Youngstown, Anderson College, Scotland; Theodore Benjamin Thoma, Steubenville, Jefferson Med. College; Benjamin Chee Keong Tom, Dayton, Hahnemann Med. College; Norman Traverse, Columbus, Univ. of Tennessee;

John Wade Walker, Jr., Univ. of Louisville; Robert Owen Webster, Cleveland, Univ. of Michigan; Cornelius Calvin Welch, Cleveland, Creighton Univ.; Paul Roberts Winslow, Columbus, Univ. of North Carolina.

Dr. Anderson Is Named to Post as Mental Hygiene Commissioner

Dr. Robert C. Anderson has been named state commissioner of mental hygiene, a position which makes him chief of the Division of Mental Hygiene, Dr. Robert A. Haines, director of the Department of Mental Hygiene and Correction, announced.

Dr. Anderson is a graduate of the University of Indiana Medical School, who came to Ohio last November after serving six years as manager of the Veterans Administration Hospital in Topeka, Kansas. He had also been clinical director of that institution since 1946.

He is a fellow of the American Psychiatric Association and is certified by both the American Board of Psychiatry and Neurology and by the American Psychiatric Association as a mental hospital administrator.

Dr. Anderson succeeds Dr. Joseph E. Duty, who resigned from the state post for health reasons. Dr. Duty returns to his post as superintendent of the Toledo State Hospital, a position he held for 11 years prior to becoming state commissioner last fall.

Dr. William Wells, of Newark, Is 1958 OSMGA Golf Champion

The Ohio State Medical Golfers' Association returned to the Springfield Country Club for its 1958 tournament. One hundred and twenty-five medical golfers participated in this year's play and enjoyed the difficult but beautiful Springfield course. The weatherman, often a conspirator against the golfing medics in the past, cleared the skies for 10 o'clock tee offs and kept them so until late afternoon when a cloudburst drenched late starters. Spirits were revived by the cocktail party given by the Clark County Medical Society preceding the annual banquet. Dr. Ray Turner, chairman of the Springfield Committee, provided arrangements and hospitality.

Dr. William Wells from Newark, captured the medical golfers' crown with a low gross of 39-35-74. His name will join previous champions on the W. D. Inglis Trophy. The champion is also awarded a replica of the large beautiful Inglis Bowl for permanent possession. Dr. Inglis of Columbus, a founder and early champion of OSMGA presented the trophy to the Association last year. Dr. Avis Franklin, Akron, and Dr. Earl Pinnell, Dayton, were tied for runner-up position with low gross of 75.

Other winners in age classes were awarded silver bowls and were as follows:

39 years and under
Low Gross—Avis Franklin, Akron
Low Net—L. M. Haley, Dayton
49 years and under
Low Gross—William Lovebury, Columbus
Low Net—J. Woodward, Euclid
59 years and under
Low Gross—G. E. Huston, Marietta
Low Net—H. R. Johanson, Kenton
69 years and under
Low Gross—H. D. Emswiler, Columbus
79 years and under
Low Gross—W. C. Fargo, Cleveland

Officers for 1959 elected by the membership were: President-Elect, John C. Stahler, Dayton; Vice - President, William Lovebury, Columbus; Secretary-Treasurer, Bob Elwell, Toledo. President Paul Stoodt, Mansfield, conducted the business meeting of the Association following the banquet of filet mignon and lobster and then installed the new president, Edward Sawan of Akron.

Dr. Sam Vinci of Cleveland, extended an invitation to the OSMGA to hold the 1959 tournament at the Accacia Country Club in Cleveland, which was unanimously accepted by the membership.—Robert Elwell, Secretary,Treasurer.

Eighth District Meeting Scheduled In Zanesville, October 2

The Annual Eighth District Medical Meeting is scheduled for Thursday, October 2, in Zanesville. Quarters for the meeting will be the Zanesville Country Club. The scientific meeting will be a symposium during the afternoon on "Neurological and Neurosurgical Disease." An evening dinner for physicians and their wives is planned. Additional information will be published in the September issue of *The Journal.*

ANA Acts on Health Insurance And Collective Bargaining

At its recent meeting in Atlantic City, the American Nurses Association acted on a wide variety of subjects, among them government health insurance and greater economic security for nurses. These significant actions were described as follows in the July issue of *The American Journal of Nursing:*

For the first time since 1952, the House of Delegates reviewed its policy on taking a position on national health insurance. Believing that the disabled, retired, and aged are neither eligible nor able to avail themselves of voluntary health insurance, the delegates adopted a resolution that the ANA support the principle of extending and improving contributory social insurance to include health benefits for recipients of old-age, survivors, and disability insurance, and that nursing services be included as a benefit of any health insurance program.

"In response to inquiry from the floor whether this action committed the ANA to support the Forand bill, the chairman of the committee on legislation said that it did not commit the association to support any particular bill. It did give the ANA Board the authority, she said, to review any bill on the subject in Congress and to support the bill or bills if they agreed with the principle expressed in the resolution, or to recommend changes."

* * *

"The delegates moved to strengthen the position of state nurses associations in collective bargaining with hospitals by adopting a resolution calling on the American Hospital Association and its constituents to join with the ANA and its constituents in implementing the essential procedures of collective bargaining: freedom of employees to organize; free choice of representation; recognition of employee representatives and bargaining in good faith by representatives of employers and employees; negotiation of agreements signed by both parties."

Selling Price of Medical Practice . . .

Facts, Comments and Suggestions on This Subject are Made by Director Of the AMA Bureau of Medical Economic Research Following a Survey

NOT infrequently, the Columbus Office is asked this question: "I want to sell my practice—What about the price?" Or, it is asked this question: "I have been offered a practice—What is a fair price for me to pay for it?"

There can be no cut and dried answers to these questions. Nevertheless there are some basic matters which should be taken into consideration by either the seller or the buyer.

One of the best articles on this subject was that prepared by Frank G. Dickinson, Ph. D., director, of the AMA Bureau of Medical Economic Research, several years ago, following a survey of secretaries of state medical societies and other sources.

Text of Article

Following is a part of Dr. Dickinson's article:

Some time during his professional career, a physician may face the problem of buying or selling a practice. After the physician completes his internship or residency, he may consider purchasing the practice of an older physician. After establishing himself in private practice, he may for various reasons contemplate a change of location, involving both the sale of his own practice and the purchase of another elsewhere. Following the retirement or death of a physician the sale or disposal of his practice may be considered.

The sale or purchase of a medical practice raises many questions; a considerable number of requests for information and advice are received at the headquarters of the American Medical Association. Perhaps the most frequent question concerns the means of establishing a proper selling price for a practice. But little has been published on this subject recently. Thoroughgoing studies have not been made of either the economic or legal aspects; nor have there been any compilations of actual experiences. The Bureau of Medical Economic Research recently conducted an informal survey among secretaries and executive secretaries of state medical societies and accumulated available facts from other sources.

Information and Suggestions

Current information concerning physicians' practices which are for sale may be obtained from several sources. A few state societies reported that they occasionally provide clearing-house facilities between parties; possibly most other societies would be willing to furnish available information. The medical journals are probably the most important source for such opportunities—including the classified advertising sections of local, state and national publications. Other avenues of approach for either the buyer or seller are medical placement agencies and inquiries among professional acquaintances. In addition, a physician wishing to purchase a practice may offer an advertisement.

Many of the secretaries of medical societies commented on the factors to be evaluated in ascertaining the selling price of a practice. Most of them considered that the tangible goods could be appraised readily but suggested that pricing of intangibles was extremely hazardous. The following is a list of types of goods, together with comments and suggestions, developed from available sources:

1. **Real and Personal Property and Equipment.**—Medical equipment, supplies and the physician's residence (if this is included) may be appraised by real estate brokers, equipment dealers and other consultants in order to establish a fair market value. Most authorities felt that these constituted the basic, if not the only value, of a medical practice.

2. **Transferable Contract Appointments.** — If the seller holds appointments as an industrial consultant or house physician, or holds other positions providing a salary or other regular remuneration, the possibility of transferring these to the buyer may be explored. A value equal to an agreed percentage, perhaps of the annual income for the first year, may be established for this assured income.

3. **Lease of Office Space and Residence.**—While housing and office space continue to be in short supply in many parts of the country, a money value may be established for the transfer of leases on desirable space of this nature.

4. **Uncollected Bills.**—Bills for current services to patients or for relatively recent services may be transferred to the new physician for some consideration, or other arrangements for collections may be made which will be mutually agreeable. Often, the selling physician or his heirs will retain them for collection through their own agents.

5. **Goodwill.**—A formula or procedure has not been suggested which might be used consistently to establish a cash value for goodwill. One secretary commented, "I am of the personal opinion that it is absolutely impossible for a physician to set a price on goodwill or the value of a prac-

tice as such." Another stated, "It depends to a great extent on the value of services, character and personality. One doctor may not be able to give the same services as the previous physician, or to pick up and use the goodwill left behind because of difference in personalities or other intangibles, and thus may lose all the goodwill." The general conclusion was that since the personal element is so important in the services provided by a physician, it may not be valid to assume that a physician's goodwill can be sold in the same fashion as a manufacturer's or a retail store's goodwill.

6. **Patients' Records.**—The problem of evaluating patients' records as to goodwill is even more difficult. Case histories, diagnostic reports, financial and other records can be of great value in assisting a new physician in the treatment of patients of the former physician. Many secretaries, however, felt that patients' records were essentially intangibles and therefore difficult to price. In addition, one secretary pointed out that ethical and legal issues are involved in transferring such records to a buyer without the patients' consent. To some extent this objection may be overcome if arrangements are made to have the buyer introduced to the community by the retiring physician as a professional associate for a period of time. Several secretaries felt that this is a more valuable arrangement in rural areas than in urban areas.

No Rules of Thumb

The buying physician may agree that the location, introduction to old patients or other circumstances will assure a steadier patient load than if he were to start a practice without these advantages. Basically, any inherent money value in these intangibles is reflected in the number of old patients who will continue to come to the buying physician. The buying physician may agree to pay the seller a given percentage of net income received from old patients during the first year or two; new patients during the first year may or may not be considered a separate or additional goodwill item. It should be clear to both parties that generalizations or "rules of thumb" regarding the probable percentage of old patients who will accept the new physician are open to serious question when applied to a given situation. Since prediction is so hazardous, both parties would be well advised to provide for final determinations of this item of goodwill a year or two later, although the formula may be set forth in the contract. This arrangement is considered also in cases in which a partnership or group is dissolved, but often it will involve much more complex formulas for establishing the interest of each member.

Careful consideration from the point of view of medical ethics should be given to any mutually satisfactory arrangement providing payments for the goodwill item out of future income or basing the value of this item on future income.

Specialty Practice

The question of sale or purchase of a specialty practice involves further difficulties. As a specialist depends greatly on referred patients, greater care must be taken to verify the continuation of a sound relationship with referring physicians. A general suggestion, both for a specialty practice and for a general practice, is to consider employment of a young man on a salary basis, with agreement as to terms of eventual sale or shift to partnership activity. In some instances such an agreement might prove more satisfactory to both parties than an outright sale.

Conclusions

The physician should exercise extreme care in arranging to sell or purchase a practice. Perhaps the best statement on the problem is the following by one of the state secretaries:

> The location, the type of practice, the size of the practice and the competition that is present are all factors which must be considered in each individual sale, and it appears that probably there is no formula that can be set up—even with an area such as a state—that would assist in any individual transaction. I am inclined to look on this as an individual business venture that would depend entirely on an agreement between the parties concerned. Even though in the eyes of every one else the purchase price was too high or too low, if it was agreeable to the two parties concerned, it would still be a happy transaction. And for those reasons, it has been the opinion of the society that it would not interfere or attempt to offer any assistance to persons contemplating the purchase of a practice.

Because of the extremely involved professional and financial interests arising out of such negotiations, the Bureau of Medical Economic Research strongly urges that principals make no final arrangements without the assistance of their attorneys. This is especially true if the transaction cannot be consummated at once but involves payments or professional relationships, such as partnerships, which extend over a period of time.

One alternative to the purchase of a practice was suggested by several secretaries—the establishment of a new practice in a community. If, after exploring the advantages and disadvantages of buying a given practice, it appears that there is no singular value in the location, type of practice or tangible goods, the physician can given serious consideration to the selection of another location in the community. It is this alternative which largely accounts for the infrequency of sales and the tenuous value of the goodwill item in medical practices in the United States.



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SEARLE

*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

Columbus Academy Announces "Clinic Day" Nov. 1

The Columbus Academy of Medicine has announced plans for the second annual "Clinic Day" program to be held Saturday, November 1 at the new Franklin County Veterans Memorial Building, 300 W. Broad Street in Columbus. Interested physicians of other counties are invited to attend.

The program announced by Dr. Arthur G. James, general chairman, includes nine out-of-state speakers. Final details will be announced in other issues of *The Journal,* and plans for pre-registration will be given.

Registration will begin at 8:30 a.m. with the first program feature at 9:30. The following speakers with the topics on which they will speak have been announced:

Morning Program

Dr. Paul Hodges, professor of radiology, University of Chicago, "Radiation Hazards in medicine."

Dr. Ray W. Gifford, consultant, Section on Medicine, Mayo Clinic, Rochester, Minn., "Fat, Diet and Atherosclerosis."

Dr. Rachmiel Levine, chairman, Department of Medicine and director of metabolic and endocrine research, Michael Reese Hospital, Chicago, "Newer Agents in Diabetes."

Dr. Robert J. Samp, Department of Surgery, Tumor Clinic, Wisconsin University School of Medicine, "Prevention of Cancer, Forty Possible Means."

Afternoon Program

Dr. Joseph E. Murray, Boston, Mass., "Experiences with Kidney Transplants."

Panel Discussion on Care of the Advanced Cancer Patient; Moderator, Dr. Charles A. Doan, dean of the Ohio State University College of Medicine.

Panel Collaborators: Dr. George T. Pack, attending surgeon, Memorial Hospital, New York City; Dr. Chester Southam, associate, Sloan-Kettering, New York City; Dr. Bronson S. Ray, professor of neurosurgery, Cornell University, New York City; Dr. James W. Carpender, professor of radiology, University of Chicago.

Cleveland—Dr. George Austen, Jr., Western Reserve University School of Medicine faculty member, has accepted the post as chairman of the Department of urology and professor at the Boston University School of Medicine.

Wakeman—Two new physicians who recently elected to practice medicine in Wakeman were honored by the community at a reception in the Townsend-Wakeman High School Auditorium.

Still Time To Order

Doctor, you still have time to order the two pamphlets—"Do You Like to Make Decisions?" and "The Fifth Freedom"—which you received samples of in your June 16 *OSMAgram.* Your colleagues found these pamphlets on free choice and mutual understanding very effective. They ordered them in considerable numbers and you may do so without charge by writing OSMA Headquarters. Be sure to include your return address and the number of copies of each pamphlet you want. Ten copies or 1,000, we have them for you.

Do You Know?

OSMA Executive Secretary Charles S. Nelson participated in a round-table discussion of "The Doctor and His Medical Society," which appeared in the May issue of *The New Physician* as one of a continuing series in the Student AMA publication.

* * *

Governor C. William O'Neill has reappointed Dr. Claude S. Perry, Columbus, to the Ohio Commission for the Blind. The new five-year term ends in July, 1963.

* * *

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was elected first vice-president of the American College of Physicians at the recent Atlantic City convention.

* * *

Dr. Margaret Jane Schneider, Cincinnati, was elected first vice-president of the American Medical Women's Association at the recent annual meeting in San Francisco.

Ohioans Will Speak at Rhinologic Program Scheduled in Chicago

Two Ohio physicians are scheduled to appear on the program of the American Rhinologic Society in Chicago, October 17-18. The meeting will be at the Palmer House.

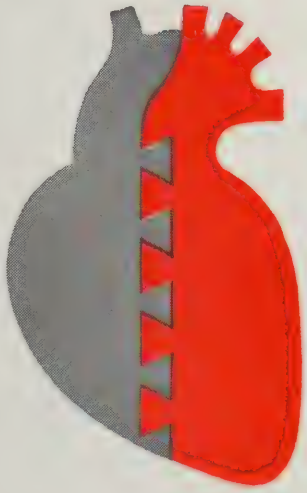
Dr. Harvey C. Gunderson, Toledo, will speak on the subject, "Second Golden Decade of Rhinologic Surgery—Advances of the Past 10 Years."

Dr. Irving Cramer, Cleveland, will speak on "Nasal Physiology."

Details may be obtained from the secretary, Dr. Robert M. Hansen, 1735 North Wheeler Ave., Portland 17, Oregon.

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Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 18 B

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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Guardianships . . .

Here Is a Practical Discussion of the Medical Aspects of This Subject Particularly as It Relates to Physicians Who Undertake To Treat Wards

AN attorney with a good deal of experience in matters of guardianships wrote this informal discussion of the nature of guardianships with emphasis on certain responsibilities and hazards which a physician may face when involved in treating patients who are wards. The author is Clarence C. Fowerbaugh, Cleveland, and the article is quoted from the *Bulletin of the Cleveland Academy of Medicine.*

* * *

The creation of the relationship of guardian and ward in Ohio is statutory and is a legal device protecting such person as is incapable of caring for himself, owing generally to incompetency or minority.

"Incompetency" applies to any person who by reason of advanced age, improvidence or mental or physical disability or infirmity is incapable of taking proper care of himself or his property or fails to provide for his family or other persons for whom he is charged by law to provide.

One under 21 years of age in Ohio is a minor and is entitled to a degree of protection by virtue of being a minor.

Type of Guardianship

Guardianship may be established of the person, the estate or the person and estate. A guardian of the estate is, to a great extent, only a business or financial manager. A guardian of the person, in the case of a minor, stands in the relationship to such child as a parent or parents. This invests the guardian with the right of choice of schools, place to live and other incidents of the parent-child relationship. The guardian of the person of an adult who is incompetent, regardless of cause, stands in a position of a protective relation-





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ship, making the decisions for his ward the same as he might do if competent.

In Ohio, the probate courts have jurisdiction of all guardianships, that is, their creation, continuance and supervision. While a guardian may be removed for cause by the Probate Court, such Court cannot be expected to substitute its judgment in routine decisions for that of the guardian.

In general, a physician is not needed in the creation of a guardianship-ward relationship as it applies to minors. Parents, or surviving parent, are the natural guardians of their minor child or children. In most instances where the guardianship is created for a minor, the child is an orphan or has been abandoned by his parents so that some other person must be appointed to stand in the legal parent-child relationship toward the child.

Medical Necessity

To create the guardianship-ward relationship with an adult, the courts, except in certain limited instances where the written consent of the ward is given, require medical evidence as to the necessity for the appointment of a guardian. Frequently the creation of the guardianship for an adult is denied entirely because of medical testimony. Courts do not have a guardian appointed merely because another can do a better job of managing his person and property.

Habitual drunkenness, insanity, imbecility, mental illness, physical infirmity and advanced age constitute the common grounds for the appointment of a guardian. The role of the physician in the diagnosis of such conditions is readily apparent.

The law as a protective device for the ward, requires that the guardian be bonded, and that periodic accounts of all income and expenditures be filed. While the guardian serves the ward, the Probate Court keeps the guardian under surveillance with the view of seeing that a high degree of protection is afforded the ward.

A minor, in general, is not liable in contract except for necessaries, and an adult dealing with a minor, with the above exception, does so at his own peril. The guardianship of an adult, to a great extent, removes the contractual rights and privileges of such adult ward. The guardian handles the ward's finances, pays his bills and does his contracting for him. The appointment of a guardian, in almost all instances, deprives the ward of the right to drive a car. One dealing with an adult ward, in general, does so at his own peril.

A guardian is not liable out of his own assets to support, maintain and pay medical expenses of his ward. Such payments must come out of the guardianship estate. A guardian may, by contract,

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SURGERY—Surgical Technic, two weeks, Sept. 15, Sept. 29. Surgery of Colon and Rectum, one week, Sept. 22, Oct. 27. Basic Principles in General Surgery, two weeks, Oct. 13. Gallbladder Surgery, three days, Nov. 3. Surgery of Hernia, three days, Nov. 6. General Surgery, two weeks, Nov. 10; one week, Oct. 27. Fractures & Traumatic Surgery, two weeks, Oct. 20. American Board Review Course, two weeks, Nov. 10. Blood Vessel Surgery, one week, Oct. 20.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 8. Vaginal Approach to Pelvic Surgery, one week, Oct. 6. General & Surgical Obstetrics, two weeks, Sept. 22.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3. American Board Review Course, one week, Sept. 29. (For Part 1 Candidates Only)

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Two-Week Intensive Course, Oct. 13. Ten-Day Practical Course in Cystoscopy by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 22. Clinical Uses of Radioisotopes, two weeks, Sept. 29.

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References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

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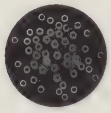
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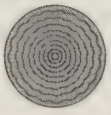
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bind himself to pay out of his own assets obligations of his ward, but this does not generally occur.

Points To Watch

A physician, in dealing with an incompetent or with a guardian, should be aware of the following:

1. If a ward calls a physician for medical services, unless it be an emergency, the doctor may run the risk of not being paid by the guardian.

2. The guardian and not the ward has the legal right to choose a physician and to select the hospital, if this should be necessary.

3. In all instances, except emergencies, where written consent for treatment, shock therapy, operations and hospitalization are required, the guardian gives such consent and not the ward.

4. Payments for such services are made by the guardian and not by the ward, even though the actual funds come from the ward's assets.

5. The guardian relationship terminates upon the death of the ward, so that the guardian is not in a position, legally, to consent to an autopsy.

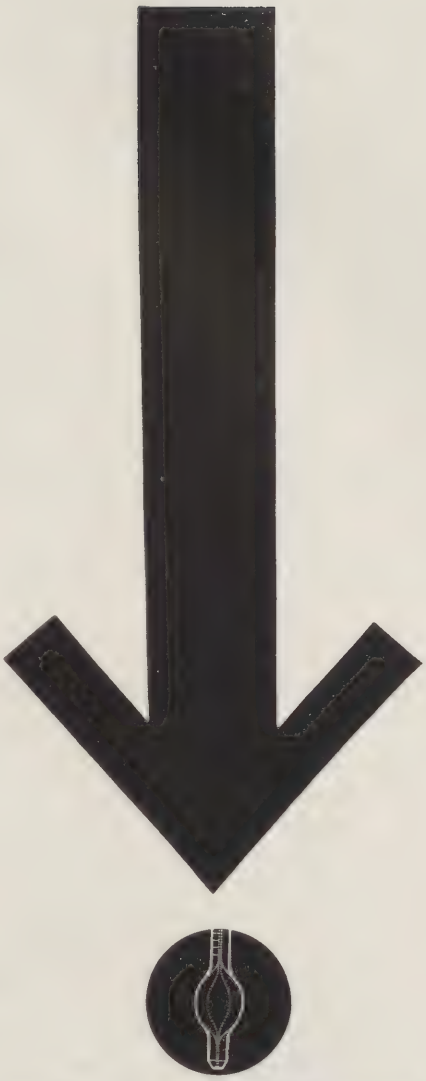
6. A guardian, in most jurisdictions, is not in a position to consent to his ward's sterilization. In Ohio, in absence of statutory authority, the guardian cannot consent on behalf of his ward to sterilization, and the ward being incompetent or incapable of contracting, cannot consent on his own behalf.

7. A physician, in recommending to a probate court whether or not a guardian is necessary for an adult person, should be free from bias or prejudice and should use his best professional experience. The fact that a person has made a series of errors in business judgment is not sufficient cause for a guardianship. Limited intelligence, alcoholism and mildly advanced cases of senility may not be sufficient reasons to require a guardian.

8. The fact that another may handle his ward's financial assets better is not a basis for the appointment of a guardian. One has the right, in our democracy, to a certain number of errors of judgment.

Professional Opinion

A physician may find himself in a delicate situation, particularly when requested to examine a patient either as to the necessity for appointment of a guardian or the termination of a guardianship. Suppose the friend of the alleged incompetent requests the services of a physician prior to the appointment of a guardian and it is the doctor's opinion that a guardianship is unnecessary, such doctor cannot legally demand payment for his services by the alleged incompetent as there was no express or implied promise of compensation. If the person requesting the services originally



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Thiamine hydrochloride	2.5 mg.
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*Potency established before formulation.

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does not make the payment, the doctor can usually add this experience to his accumulated charitable endeavors.

In a recent situation in an existing guardianship, an acquaintance of the ward sought the services of a physician in having the guardianship terminated. After extensive medical examination by the physician and by a physician obtained by the guardian, it was their medical opinion that the guardianship should not be terminated. The physician engaged by the guardian was paid promptly out of the ward's assets for his services rendered and for benefits to the ward. The other physician, while acting in good faith, was not paid by the person who engaged him, and as he had not been engaged by the guardian, there was no legal obligation on the part of the guardian to pay.

A guardian cannot be unjust, unreasonable or arbitrary in his relationship with his ward or with others, as he is under the jurisdiction of the court. The guardian is the person vested with the responsibility for his ward.

Doctors' Appeal for Radio Frequencies Temporarily Rejected by FCC

Separate requests by American Medical Association and American Hospital Association for exclusive radio frequencies for use of physicians and hospitals have been temporarily rejected by the Federal Communications Commission in one classification, but a FCC spokesman said their overall appeals still are under consideration with the possibility they eventually will be made eligible in several other classifications.

In the same ruling the FCC set up a new classification, "Business Radio Services," and made doctors and hospitals eligible for frequencies in it. However, under these conditions the medical profession would have to compete with all community businesses for the frequencies.

They are also eligible in the "Special Emergencies" and "Citizens Radio" classifications, but under restrictions and competitive conditions that would not make these frequencies attractive to doctors or hospitals.

The AMA and AHA still have a right to make a new appeal for frequencies in the "Industrial Radio Services" category, in which their original request was denied.

Doctors are asking for protected frequencies for physicians for day-to-day use, to receive and answer emergency calls, for undergraduate and post-graduate medical training, and for use in disasters or medical emergencies. The hospitals want the service for day-to-day and emergency use.





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Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.



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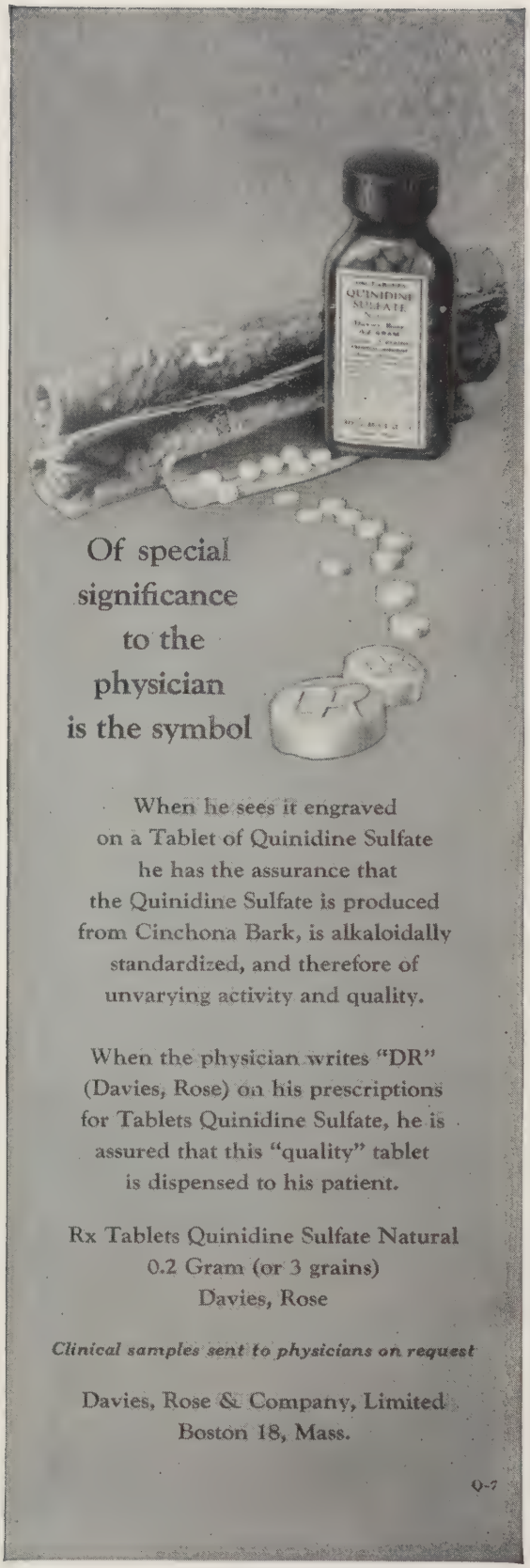
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New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since June 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Ashtabula County
Richard S. Millberg, Andover

Clark County
John W. Rechsteiner, Springfield

Cuyahoga County
Alfred K. Bochner, Cleveland
Sylvester S. Davis, Jr., Cleveland
Aaron J. Fine, Cleveland
Antoine M. Harouny, Cleveland
Wade S. Helwig, Cleveland
Louise J. Keating, Cleveland
Juan H. Montier, Cleveland
Gaetano Roncagli, Cleveland
Myra Sahajdak, Cleveland
Robert K. Saylor, Cleveland
Carlos A. Schaffenburg, Cleveland
Burton J. Shapiro, Cleveland
Chandler Smith, Cleveland
Nancy Cole Wallick, Cleveland
Robert W. Wido, Cleveland
Stephen N. Wiener, Cleveland
Herbert L. Winograd, Cleveland

Franklin County
Talivaldis Berzins, Columbus
Arthur L. Clark, Columbus
Robert J. Dane, Columbus
Morton L. Harshman, Columbus
Thomas L. King, Columbus
Norloso B. Livingston, Jr., Columbus
Jacob W. Old, Jr., Columbus
William T. Paul, Columbus
Ivan G. Podobniker, Columbus
Bartholomew D. Ragucci, Columbus
Ruth H. Ragucci, Columbus
Norman E. Sindel, Columbus
Nichols Vorys, Columbus

Hamilton County
Robert T. Bliss, Cincinnati
Harry H. Boss, Cincinnati
Thomas E. Finn, Cincinnati
Thomas L. Linn, Cincinnati
Paul H. Ornstein, Cincinnati
Chester M. Pierce, Cincinnati
Edward A. Rowat, Cincinnati

Harrison County
Kurt W. Michaelis, Hopedale

Lake County
Hellmuth E. Simon, Painesville

Lorain County
John J. Harrington, Lorain

Putnam County
Charles R. Kidd, Kalida

Richland County
Val Berzzarins, Lexington

Summit County
Alfred C. Buergler, Akron

Middlefield — The Middlefield Chamber of Commerce has named as its "Man of the Year" for 1957, Dr. Hubert Shafer, for his 31 years of medical service and community leadership.

Zanesville—A Bradenton, Fla., general practitioner, Dr. R. O. Jones, has been named commissioner of the Muskingum and Guernsey County Health Departments. Dr. Jones, M. P. H., succeeds the late Dr. Margaret O'Neal.



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Medical Progress Cited By Laymen in AMA Journal

"Partners in Progress" was the subject of a special salute to medicine on the occasion of the seventy-fifth anniversary of the *Journal of the American Medical Association.*

The salute was composed of a series of 20 articles tracing the interdependence of medicine and the community. They appeared in the July 12 *Journal of the AMA.*

Only one physician—Dr. Gunnar Gundersen, AMA president—was included among the authors. The remainder are acknowledged lay leaders in the fields of business, commerce, and industry.

Explaining why laymen were asked to contribute articles to a medical publication, Dr. Austin Smith, editor of the *Journal,* said "too often our eyes and our thoughts remain confined to our own fields of interest without realizing how much each field contributes to another."

We are all "partners in progress," he added, and no field of human endeavor can be isolated from the rest of the community.

Those who contributed articles for the *Journal's* anniversary were:

A. P. Beutel, vice-president and general manager, Dow Chemical Company; Roger M. Blough, chairman of the board, United States Steel Corporation; L. L. Colbert, president, Chrysler Corporation; John Daly, vice-president, American Broadcasting Company; James E. Day, president, Midwest Stock Exchange.

Walt Disney, chairman of the board, Walt Disney Productions, Ltd.; Frederic W. Ecker, president Metropolitan Life Insurance Company; Dr. Gunnar Gundersen, president, American Medical Association, Harlan Hatcher, president, University of Michigan; J. Edgar Hoover, director, Federal Bureau of Investigation, United States Department of Justice.

Charles F. Kettering, research consultant and director, General Motors Corporation; Herbert R. Mayes, editor, Good Housekeeping magazine; Fowler B. McConnell, board chairman, Sears Roebuck & Co.; Charles S. Rhyne, president, American Bar Association; Capt. Eddie Rickenbacker, chairman of the board, Eastern Air Lines, Inc.

Charles B. Shuman, president, American Farm Bureau Federation; Frank Stanton, president, Columbia Broadcasting System; John Steinbeck, author; DeWitt Wallace, publisher, *Reader's Digest;* K. L. "Tug" Wilson, commissioner, Intercollegiate Conference, and president, U. S. Olympic Committee.

In the same issue, President Dwight D. Eisenhower extended his personal "felicitations" to the *AMA Journal.*

The Chief Executive said the *Journal* is "a potent force for progress in the field of medical discovery and medical information."

Additional $6 Million Voted By Legislative for Poor Relief

At the recent special session of the Ohio General Assembly, an additional $6 million was appropriated from state funds for poor relief fund matching with the local relief areas. It is estimated that this will permit the state to meet its 50-50 matching obligation to February, 1959, when the General Assembly in regular session will take another look at the poor relief financial situation.

Buckeye News Notes

Bellefontaine—The Bellefontaine Kiwanis Club has bestowed its distinguished service award on Dr. A. J. McCrecken.

Cleveland—Dr. E. Perry McCullagh was installed as president of the National Endocrine Society at San Francisco June 19.

Dayton—Dr. Thomas P. Sharkey was elected treasurer of the American Diabetes Association at the group's 18th annual meeting in San Francisco June 22.

East Liverpool—Dr. C. H. Bailey recently was enrolled as a member of the University of Michigan Emeritus Club, whose members graduated 50 years or more ago. Dr. Bailey received his medical degree in 1908.

Garfield Heights—John R. Lawrence Post 304, American Legion, has named Dr. Charles Blaugrund its 1957 "Man of the Year."

Gomer—Dr. and Mrs. O. S. Robuck on June 22 observed their golden wedding anniversary. Dr. Robuck has been a patient in Lima Memorial Hospital since a fall March 11.

Hamilton—A Philadelphia, Pa., physician, Dr. Alexander Witkow, has assumed the position of director of public health for Hamilton and Butler County.

Marysville — New health commissioner for Union, Delaware, Madison and Morrow Counties is Dr. James P. Owen, of Cincinnati, succeeding Dr. Robert Vogel, who resigned to take a smiliar post in Montgomery County.

Toledo—Riverside Hospital's 75th anniversary was observed with a four-day celebration in June.

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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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In Memoriam . . .

James R. Jarvis, M. D., Van Wert, who in April completed the maximum of three full terms as a member of The Council of the State Association, died on June 27 at the age of 52.

Dr. Jarvis served his entire professional career in the Van Wert area where he engaged in general practice and anesthesiology. He began practice in Van Wert in 1932 upon completion of an internship at White Cross Hospital, Columbus. A native of Mansfield, he received his B. A. degree from Ohio State University and graduated from the George Washington University Medical School in 1931. His contributions to the profession were statewide in several branches of medical organization work. As a member of The Council of the OSMA he worked in close liaison with County Medical Societies in the Third District. He was also chairman of the Advisory Committee to the Woman's Auxiliary.



J. R. Jarvis, M. D.

Long active in affairs of the Ohio Academy of General Practice, he served that organization as president and previously as director of the Third District. As a member of the Ohio Society of Anesthesiology he had been northwest district councilor, and on that organization's executive committee.

He was a past-president of the Van Wert Medical Society and served the local organization in many other capacities. Other professional affiliations included the executive committee of the Northwest Ohio Medical Association, the American Medical Association, the American Society of Anesthesiologists, the International Society of Anesthesiologists, the American Academy of General Practice, and Fellowship in the American College of Anesthesiology.

Dr. Jarvis took an active interest in municipal affairs and belonged to a variety of local organizations including the Presbyterian Church, the Masonic Lodge and the Chamber of Commerce. Surviving are his widow, three sons, a daughter, his parents and two brothers.

George W. Clark, M. D., Toledo; University of Michigan Medical School, 1900; aged 85; died June 16. Dr. Clark practiced in Toledo prior to World War I. After the war, during which he served with the Army Medical Corps, he moved to Defiance where he continued in practice until his retirement in 1940. He was a member of the Inverness Country Club, several Masonic bodies and the Kettering Golf Club in Defiance. Surviving is a daughter.

Allen H. Dunton, M. D., Cincinnati; University of Michigan Homeopathic Medical School, 1911; aged 70; died June 21; former member of the Ohio State Medical Association. Dr. Dunton retired from practice about five years ago after serving virtually all of his professional career in Cincinnati, with time out for military service during World War I. His widow survives.

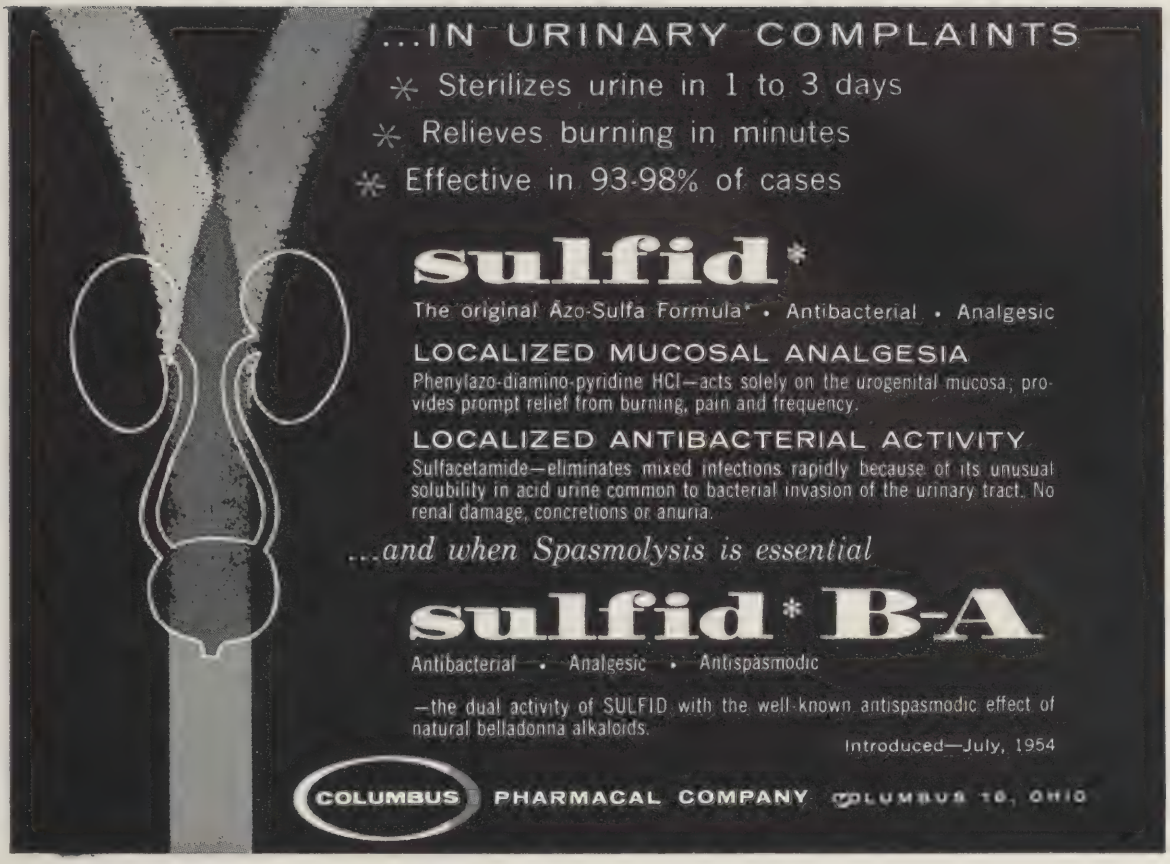
Paul M. Gordon, M. D., Cleveland; Western Reserve University School of Medicine, 1927; aged 55; died June 18; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Gordon practiced there since the completion of his medical training. He was a member of the Cleveland Yachting Club, several Masonic bodies, Phi Ro Sigma and Pi Sigma Alpha. Survivors include his widow, a son, a daughter, his mother and a sister.

Henry Jenkins, M. D., Cleveland; Toledo Medical College, 1902; aged 82; died March 31; former member of the Ohio State Medical Association. Dr. Jenkins was a practicing physician for many years in Cleveland.

Glendon E. Parry, M. D., Hillsboro; University of Cincinnati College of Medicine, 1951; aged 35; died June 18 in a traffic accident; member of the Ohio State Medical Association and the American Academy of General Practice and recent member of the American Medical Association. Dr. Parry had been a practicing physician in Hillsbor for four years. A veteran of World War II, he was a member of the local Rotary Club and Presbyterian Church. Survivors include his widow and his parents.

Ivah J. Ransbottom, M. D., Coldwater; Cincinnati College of Medicine and Surgery, 1892; aged 88; died June 20. Dr. Ransbottom practiced for many years in Celina and vicinity. He was a veteran of the Spanish-American War and World War I and served also in the Panama Canal Zone. Affiliations included memberships in several Masonic bodies and the Lutheran Church. A son with whom he resided survives.

Joseph Louis Ransohoff, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1904; aged



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78; died June 17; member of the Ohio State Medical Association, the American Medical Association, the Western Surgical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Dr. Ransohoff retired in 1950 after an active practice during which he was professor of surgery at the University of Cincinnati. His appointments included those as director of surgical services at Jewish Hospital and as director of its cancer clinic. A major in the Medical Corps during World War I, he was a member of the Queen City Club, the Losantiville Country Club and the Rockdale Synagogue. Surviving are his widow; two daughters; a son, Dr. Joseph Ransohoff of New York City; a step-daughter and three sisters.

A. W. Sage, M. D., San Jose, California; University of Western Ontario Faculty of Medicine, Canada, 1904; aged 76; died June 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Sage practiced in Kenton some 15 years before he moved to California about nine months ago. Surviving are his widow, a son with whom he made his home in California and a daughter.

Frank E. Sexton, M. D., Shaker Heights; University of Wooster, Medical Department, Cleveland, 1909; aged 75; died June 30; former member of the Ohio State Medical Association. A native of the Cleveland area, Dr. Sexton practiced there for more than 40 years. For many years he was chief of the medical staff of St. Ann's Hospital. A veteran of World War I, he was a member of Phi Beta Pi, the Catholic Church and the Catholic Physicians Guild. Surviving are his widow, two sons and two daughters.

Walter H. Sisson, M. D., Portsmouth; University of Vermont College of Medicine, 1915; aged 67; died June 28; member of the Ohio State Medical Association, the American Medical Association and the Industrial Medical Association. Dr. Sisson practiced for about 30 years in Portsmouth where he also was surgeon for the Detroit Steel Corp., Portsmouth Division. For several years he was director of the Portsmouth General Hospital Auxiliary Charity Horse Show. Affiliations included memberships in the Presbyterian Church and several Masonic bodies. Survivors include his widow, two daughters and a sister.

Sherman C. Ward, M. D., Lorain; University of Michigan Medical School, 1915; aged 66; died June 29; recent member of the Ohio State Medical Association. Dr. Ward practiced medicine for 43 years in Lorain and vicinity and served for many years as Lorain County coroner. Affiliations included memberships in the Ohio State Coroners Association, the National Coroners Association, the Methodist Church, several Masonic bodies, the Kiwanis Club, Eagles and Elks Lodges. Surviving are his widow, four sons and two stepchildren.

Guernsey County Resolution Honors Former Quaker City Physician

The following resolution was made a part of the minutes of the Guernsey County Medical Society:

"Dr. Manley S. Lawrence was born March 22, 1876 at Canton, Pa., the son of W. T. and Julia Spaulding Lawrence. He was graduated from Hiram College in 1900 and from Ohio Medical University (O.S.U.) in 1903. He practiced for the last 45 years of his life in Quaker City, O., and died Nov. 21, 1957 at the home of his daughter in Cambridge, O.

"WHEREAS: Dr. Manley S. Lawrence was a loved and highly respected member of the Guernsey County Medical Society who embodied all the wisdom, kindliness, gentleness and patience of the old-fashioned family doctor during the 54 years he spent in the practice of medicine, never failing to put the welfare of his patients first in all his endeavors.

"AND WHEREAS: Dr. Lawrence participated actively in all forward-looking projects in the communities which he served, helping in many ways to shape the course of religious, economic, educational and social progress. He also took an active part in affairs of the County Medical Society, and during his earlier residence in Noble County was one of the charter members of the medical organization which for a time existed there.

"AND WHEREAS: At the time of his graduation from medical school he was married to Miss Nella Shriver and with her established a home in which perfect companionship and loving parenthood were deftly combined and continuously enjoyed, thus setting for all their friends and neighbors an admirable example of happy American family life.

"THEREFORE BE IT RESOLVED by the members of the Guernsey County Medical Society that Dr. Lawrence was a cherished friend and respected colleague in whose passing they share a feeling of great loss with his wife and family, and they extend their deepest sympathy.

"FURTHER BE IT RESOLVED that a copy of these resolutions be spread on the minutes of the proceedings of the Guernsey County Medical Society, with additional copies to his wife, and to the *Ohio State Medical Journal* for publication therein.

"Respectfully submitted by the
Committee on Resolutions."

(Signed) C. A. Craig, M. D.
Wm. Camp, M. D.
James Toland, M. D.

Grant Promotes Birthmark Study By Columbus Physicians

A team of Franklin County physicians will conduct a "study of hemangiomatous tumors of early childhood," as the result of a grant of $4550 toward that project by the American Cancer Society.

Principal investigators are Dr. John C. Trabue, Dr. H. William Clathworthy, Jr., and Dr. James R. Lloyd. Others in the study group are Dr. Thomas E. Shaffer, Dr. Arthur G. James, Dr. Ben Kirkendall, Dr. Eldred B. Heisel and Dr. Thomas Pomeroy.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

CLINTON

Members of the Clinton County Medical Society held a brief business session at the monthly luncheon meeting at the General Denver Hotel Tuesday (July 1). A guest was Bob Davies, medical student who is a member of the Ohio preceptorship program. He was with Dr. Edmund Yantes and the others had the opportunity of talking with him about the program following the meeting.

Injections to prevent rabies were one of the topics since there have been several instances of rabid animals recently and a standard charge for all doctors to make was agreed on.

Dr. Yantes reported on social security and Dr. R. R. Buchanan on the progress of the health survey being made by the Clinton County Health Council.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

MIAMI

Medical problems in connection with the county-wide Civil Defense organization were discussed at the regular meeting of the Miami County Medical Society on June 6. Physicians were joined by the administrative and nursing supervisors of the county's three hospitals.

Dr. George Upton, medical director of the Miami County Civil Defense organization, presented a brief talk. Remarks were also made by V. R. Baker, county Civil Defense chief.

Emergency surgical teams were appointed for each hospital in the county. The Society also agreed to sponsor a demonstration Civil Defense hospital field unit at the county fair if such a unit becomes available.

MONTGOMERY

A special meeting of the Montgomery County Medical Society was held on June 12. There were 135 persons present. Dr. A. V. Black, president, called the meeting to order. "Purpose of the meeting: To consider recommendation of the MCMS Executive Council that the Society endorse and actively promote the establishment of a Medical School in Dayton."

Early in April the Ohio Commission on Education Beyond the High School recommended the establishment of a fourth medical school in Ohio. Three possible sites for such a school were mentioned, among them, Dayton.

After discussion, the motion passed "that the Society endorse and actively promote the establishment of a medical school in Dayton."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

Members of the Ashtabula County Medical Society and the Ashtabula County Bar Association with their wives met on June 7 at the Swallows Restaurant for a program and dinner.

Speaker for the occasion was Sherlock Holmes Evans, Massillon attorney, author and actor. Dr. Walter Brown, Conneaut, president of the Medical Society, spoke for physicians and Walter Barsky, president of the Bar Association, for the attorneys.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Dr. James Krieger, chief of the Division of Gynecology, Cleveland Clinic, was guest speaker at a dinner meeting of the Columbiana County Medical Society on June 10 in the Hotel Wick at Lisbon. His subject was "Uterine Malignancy."

MAHONING

A panel of five physicians from Ohio State University's School of Medicine reported on heart research at a meeting of the Mahoning County Medical Society Tuesday night (June 18) at Squaw Creek Country Club.

Dr. Charles A. Doan, dean of the college, was moderator, before some 125 district physicians. The physicians reported on heart research conducted under the auspices of the Bremer Foundation, established by the will of the late Richard P. Bremer, prominent Youngstown businessman who died in 1953. The Bremer Foundation set aside funds for the advancement of medicine and surgery, especially in the field of heart disease.

Dr. Doan said that the foundation funds had contributed toward making the Ohio medical college one of the finest in the nation.

Each physician on the panel discussed a phase of heart research.

Dr. Eric Ogden, professor and chairman, de-



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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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partment of physiology discussed pressure studies on dog hearts.

Dr. H. Paul Pieper, research professor, department of physiology, discussed an electronic device he has perfected which measures the relationship of pressures in the heart chambers with various heart diseases.

Dr. Nicholas Vorys, instructor, discussed research into maternity fatalities.

Dr. Howard D. Sirak, assistant professor, department of surgery, discussed open heart surgery.

Dr. Andrew Detesco, president of the county medical group, presided at the session.—*Youngstown Vindicator.*

TRUMBULL

The following notes were compiled from the Trumbull County Medical Society Bulletin of June 11 which contained a number of items on medical topics of current local interest as well as organization information.

A huge turnout made doctors' donor day for the American Red Cross program at the Trumbull Memorial Hospital on June 6 a great success. Of the 140 persons who donated blood, 24 were doctors. Others were doctors' assistants, members of their families, etc.

Seven members were listed as giving talks before local lay organizations.

Dr. Edward Marshall, Cleveland, gave a talk on "Differential Diagnosis of Acute Abdominal Pain" to the Trumbull County Chapter of the American Academy of General Practice on June 4.

The Trumbull County Medical Society accepted a proposal by the Trumbull County Tuberculosis and Health Association to conduct a six-months trial program in an effort to detect diabetes in unsuspecting persons. Under the plan each person getting an x-ray will be given one of the diabetic Drypak kits.

The Board of Trustees of the Trumbull Memorial Hospital had as guests the staff members of the hospital at Rappold's on June 25 with a late afternoon meeting followed by dinner. This is an annual affair.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society and Auxiliary met at the Belmont Hills Country Club on June 19 for a program and dinner. Speaker was Dr. Daniel W. Dickinson, of the Wheeling Clinic, who discussed the topic, "Tumors of the Lungs."

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

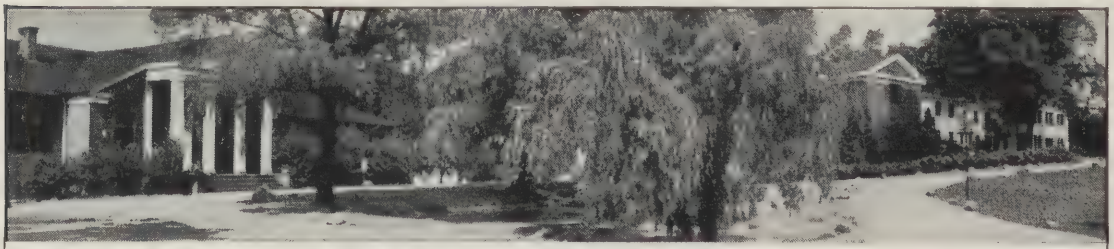
SCIOTO

Dr. Howard Sirak, associate professor and chief of the Division of Cardiovascular Surgery, Ohio State University, was speaker at the July 14 meeting of the Scioto County Medical Society in Portsmouth. His subject was "Open Heart Surgery."

Just prior to the regular meeting, the local Cancer Society sponsored the showing of the film "Uterine Cancer, The Problem of Early Diagnosis." The showing was for preview by physicians pending its showing to lay groups.

RICHLAND

The fifth annual combined professional men's golf meeting, under the sponsorship of the Richland County Medical Society, was held at the Westbrook Country Club in Mansfield on June 19, 1958, with physicians, veterinarians, dentists, pharmacists, and attorneys in attendance. After an afternoon of golf a dinner meeting was held. Members of the various professions are looking forward to the meeting next year.—John J. Clark, M. D., Secretary.



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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio
(See Page 997 for roster of officers.)

SCIOTO COUNTY

To exchange ideas, discuss mutual interests and acquaint each other with the workings of the respective groups, wives of Scioto County doctors, dentists, lawyers and pharmacists gathered at the Elks Country Club for a luncheon and afternoon program sponsored by the Woman's Auxiliary to Scioto County Medical Society, under the leadership of its president, Mrs. Armin A. Melior. Ninety women were present.

Mrs. Melior welcomed the group and expressed the hope that special projects for the good of the community could be accomplished by the combined efforts of the women. Mrs. Melior also pointed out the importance of becoming better acquainted with the individual women in each of the organizations.

By way of the workshop type program, the medical Auxiliary presented briefings on its functions and projects. Mrs. Clyde M. Fitch discussed the nurse recruitment endeavors of the auxiliary. Mrs. Samuel L. Meltzer, State auxiliary chairman of credits and awards, and Mrs. William Hugenberg gave a "repeat performance" of a Health Reporter radio interview which had recently been given over Station WPAY on the nation's medical schools and Medical Education Week. Mrs. A. L. Berndt, president-elect, explained the family health record and the wallet cards, copies of which were distributed. Mrs. W. A. Ray talked on the American Medical Association magazine, *Today's Health*. The American Education Foundation Fund of the AMA also was discussed.

Mrs. Hugenberg who is the immediate past president, was presented with a past president's pin by Mrs. Melior on behalf of the auxiliary.

The president then introduced Mrs. George W. Cooper of Waverly, Ohio, who is 9th district director of medical auxiliaries in this area.

The entertainment featured a "Geisha Girl Revue" staged by members of Twig 6 of Mercy Hospital Guild. Mrs. B. U. Howland served as mistress of ceremonies.

Bridge and canasta concluded the afternoon's entertainment.

TRUMBULL COUNTY

On May 15, the Trumbull County Medical Auxiliary met for tea at the home of the outgoing President, Mrs. Clyde Muter. The new officers for the coming year were installed by the immediate-past State President, Mrs. V. R. Frederick. Mrs. Muter gave special recognition to those who had served on her committees this past year. Mrs. James Williams and Mrs. George Mokris served as co-hostesses for this meeting. On May 21, the doctors entertained their wives at a dinner meeting at the Trumbull Country Club.

During the month of May the auxiliary members distributed posters throughout the Warren area calling attention to the importance of everyone having polio shots. On May 26, 27, and 28 they helped the school nurses give the third polio shot to school children who had not already been to their family physician.

On June 5 and 6 the Trumbull Medical Society sponsored the visit of the Red Cross bloodmobile to Warren and Niles. Auxiliary members, hospital personnel, and doctors, donated blood. Auxiliary members also helped serve coffee and doughnuts to its blood donors.

Supreme Court Rules Against FTC on Insurance

The Federal Trade Commission has lost ground in its campaign against accident and health insurance advertising. The Supreme Court in a unanimous decision held that FTC has no jurisdiction over such advertising in states that have their own laws on the subject—even though such laws are not being enforced.

Cases on the subject had been appealed by the American Life Convention, the Life Insurance Association of America and the Health Insurance Association of America.

The law authorizes federal regulation in this area only where states have not entered the field. FTC argued that in this instance the states with regulatory laws were not applying them.

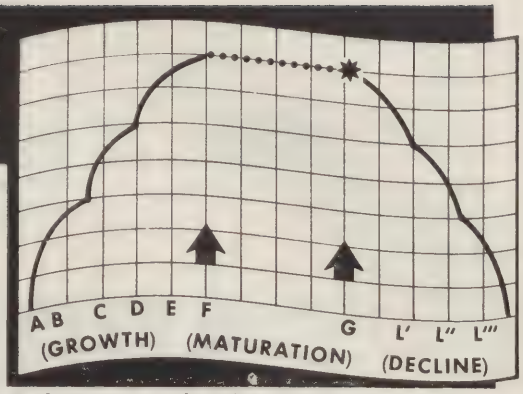
The court pointed out that the states in question have prohibitory legislation and that failure on their part to enforce it was not sufficient ground to use federal law.

New York Academy Program

The New York Academy of Medicine will hold its second annual postgraduate week (formerly the Graduate Fortnight) October 13-17. As last year, the title of the program is "Research Contributions to Clinical Practice." Details may be obtained by addressing the Academy at 2 East 103rd Street, New York 29, N. Y.

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Molybdenum	0.5 mg.	Iodine	0.15 mg.
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Copper	0.2 mg.	Zinc	1 mg.
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

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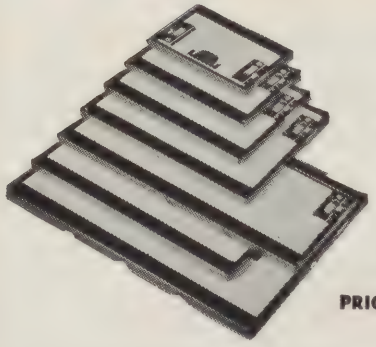
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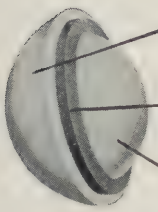
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COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

AMA Public Relations Institute, Chicago, August 27-28.

American Association of Medical Assistants, Palmer House, Chicago, October 31-November 2.

Eighth Councilor District, Annual Medical Meeting, Zanesville Country Club, Zanesville, October 2.

Ohio Academy of General Practice, Annual Scientific Assembly, October 1-2, Toledo.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

University of Cincinnati College of Medicine, Postgraduate Course in Heart Disease, Cincinnati, September 3-6.

West Virginia State Medical Association, Annual Meeting, White Sulphur Springs, W. Va., August 21-23.

General Practice Credit Announced For Cincinnati Heart Course

The University of Cincinnati has received notification from the American Academy of General Practice Regional Advisor, Commission on Education, that the seminar on Heart Disease—Current Concepts in Diagnosis and Treatment, to be given by the Cardiac Laboratory at the Cincinnati General Hospital, September 3-6, has been accepted for 24 hours of Category I credit.

Refer to July issue of *The Journal,* page 958, for the program.

Advance registration is requested. Tuition fee is $75. The course will be limited to the first 50 applicants. Applications should be sent to: Johnson McGuire, M. D., Cardiac Laboratory, B-4, Cincinnati General Hospital, Cincinnati 29.

Dr. Higgins Tours Russia and Other European Countries

Dr. Charles Higgins, head of the Urology Department at Cleveland Clinic, recently left for a 38-day professional tour of Sweden, Russia, England and various European countries. In his capacity as chairman of the board of governors of the American College of Surgeons, his schedule included a guided tour of Russian educational and public health facilities.

The tour included official appearances at the International Urological Congress in Stockholm, the Academy of Science in Vienna and the international meeting on cancer in London.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

NEW MEDICAL CENTER opening within 30 days in Solon, Ohio, fastest growing industrial area in the State. Desirable location for G. P., Pediatrician, Ophthalmologist, Radiologist and Surgeon. Contact Norton Norr, 2177 S. Taylor Rd., University Heights 18, Ohio. FA 1-0190.

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A Recent Opinion of the Attorney General

Following is the syllabus of a recent opinion given by Attorney General William Saxbe:

(1) If the estimated expenses of a general health district are in excess of revenue available within the ten-mill limitation, a special levy may be made pursuant to the provisions of Sec. 3709.29, R. C.

(2) A special levy for a general health district, imposed by a vote of the electors as provided in Sec. 3709.39, R. C., would have no application to taxable real property situated in a city receiving public health service from the general health district by contract, and such special levy should be submitted to the electors of the general health district only, which district would not include cities furnished public health service on such contract basis. Opinion No. 2294.

Southwestern Ohioans View Weekly Medical Show on Television

A medical show for Southwestern Ohio television viewers is "It's Baby Time," which is sponsored every Thursday on WCPO-TV, Cincinnati, and every Wednesday on WLW-D, Dayton, by Hospital Care Corporation, the Blue Cross Plan for Southwestern Ohio.

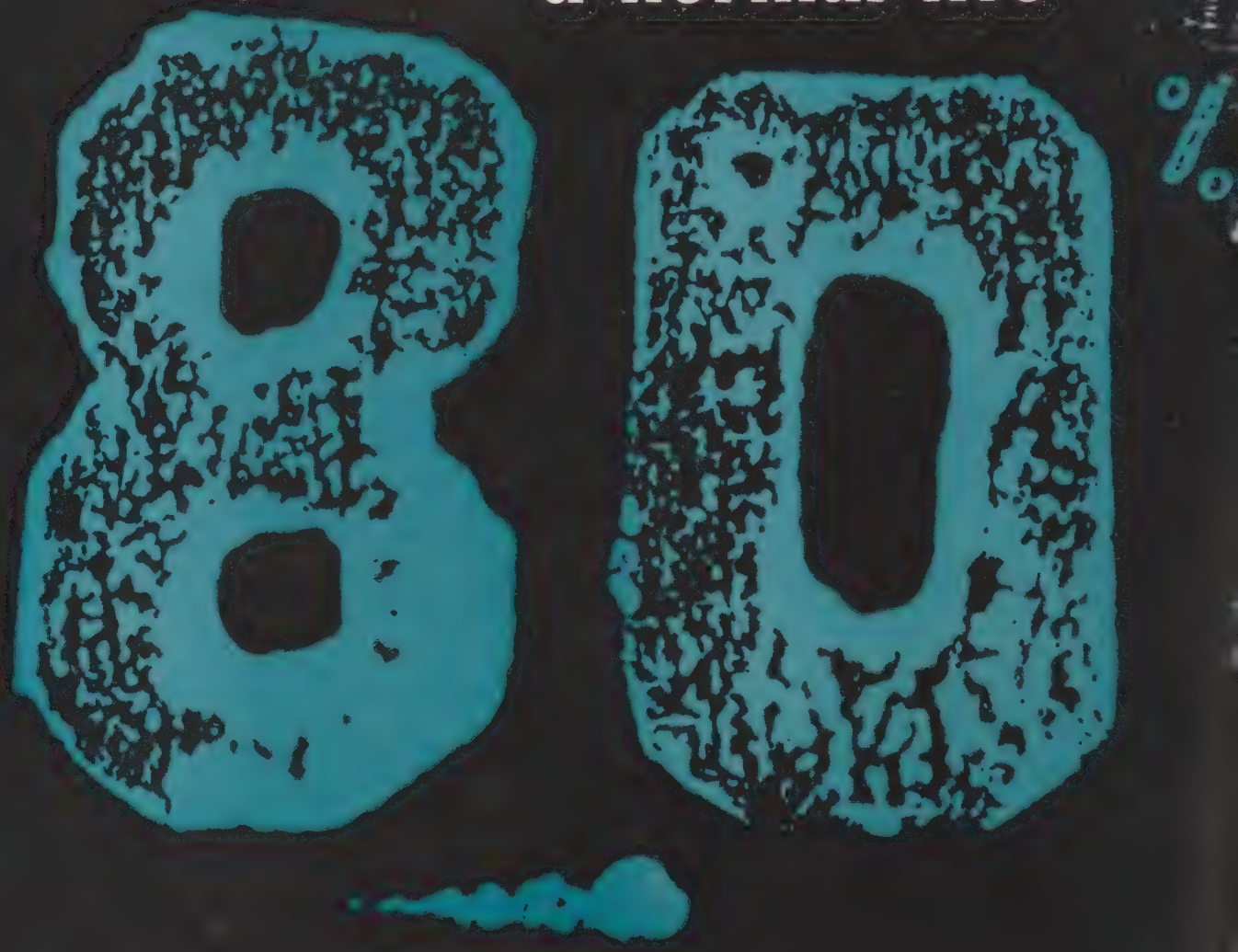
The 15-minute films, made with co-sponsorship of the Bureau of Health Education of the American Medical Association, features Dr. W. W. Bauer, AMA health director. Also featured is Jane Warren, a registered nurse. They discuss care, feeding and growth patterns of babies—allaying fears, assisting new mothers, building a greater confidence in what modern medicine is doing and can do for both mother and baby.

Blue Cross messages during the 15-minute period also point out the better hospital-medical care available today and explain why it costs what it does. Furthermore, the messages discuss the longer life span enjoyed today, the greater percentage of babies born in hospitals, and the many techniques and procedures that are helping the American people to live longer, healthier lives.

Time for the telecasts is 10:15 a. m. in each city. They began April 2 and will continue through September 30.

The 15th Annual Meeting of the American Medical Writers' Association will be held at the Hotel Morrison, Chicago, September 26.

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* Lord Cohen of Birkenhead: *British M.J.* 1:672, 1958.

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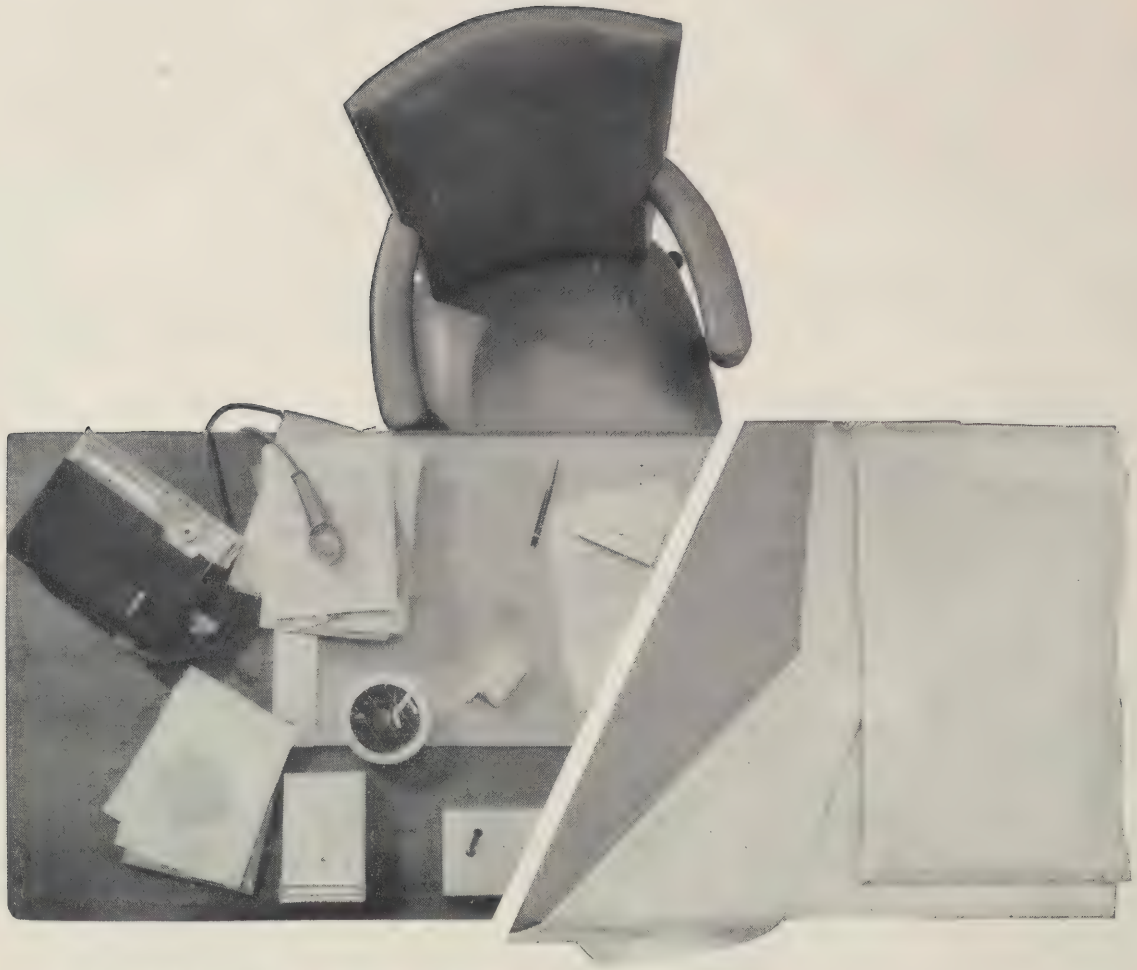
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The Ohio State MEDICAL JOURNAL

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Are You Eligible To Vote in the November 4 General Elections? Deadline for Registration Is September 24.

The Ohio State Medical Journal

Vol. 54 September, 1958 No. 9

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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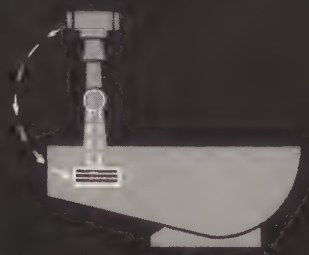
(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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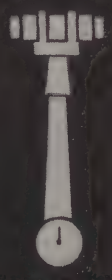
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(Continued on next page)

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County Societies' Officers and Meeting Dates

FIRST DISTRICT

ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—Donald L. Domer, President, Georgetown; Vytautas Karoblis, Secretary, Ripley. 1st Sunday, monthly.

BUTLER—John R. Perkins, President, Middletown; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Last Wednesday of alternate months.

CLERMONT—Richard D. Carr, President, Williamsburg; Harry M. Breuer, Secretary, New Richmond. Third Wednesday, monthly.

CLINTON—Roy D. Goodwin, President, Wilmington; H. Richard Bath, Secretary, Wilmington. 2nd Tuesday, monthly.

HAMILTON—George X. Schwemlein, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 152 East Fourth Street, Cincinnati 2. 1st and 3rd Tuesday, Sept. through May.

HIGHLAND—Glenn B. Doan, President, Greenfield; Kenneth Lyle Upp, Secretary, Greenfield. 1st Friday, monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

SECOND DISTRICT

CHAMPAIGN—John K. Pond, President, Urbana; William Pudvan, Secretary, Mechanicsburg. 2nd Wednesday, monthly.

CLARK—Elliott W. Schilke, President, Springfield; Martin J. Cook, Secretary, Springfield.

DARKE—V. Ray Boli, President, Greenville; Emmett W. Arnold, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Benjamin F. Lee, President, Xenia; Carl D. Hyde, Secretary, Yellow Springs. 2nd Thursday, monthly.

MIAMI—Deane B. Armour, President, Bradford; John W. Gallagher, Acting Secretary, Piqua. 1st Friday monthly, except June and July.

MONTGOMERY—Albert V. Black, President, Centerville; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton 2. 1st Friday, Jan., Feb., March, April, May and November; 1st Wednesday, June, October and December.

PREBLE—E. P. Trittschuh, President, Lewisburg. Annual meeting only.

SHELBY—Thomas W. Hunter, President, Sidney; Ned A. Smith, Secretary, Sidney. 1st Tuesday, monthly.

THIRD DISTRICT

ALLEN—Walter E. Yingling, President, Lima; Thomas D. Allison, Secretary, Lima, 3rd Tuesday, monthly, except June, July and August.

AUGLAIZE—Robert J. Herman, President, Wapakoneta; Robert S. Oyer, Secretary, Wapakoneta.

CRAWFORD—Theodore D. Sawyer, President, Crestline; R. Douglas Myers, Secretary, Crestline.

HANCOCK—Frank M. Wiseley, President, Findlay; Benjamin H. Saunders, Jr., Secretary, Findlay. 3rd Tuesday, monthly.

HARDIN—Louis A. Black, President, Kenton; William F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

LOGAN—Frederick W. Kaylor, President, Bellefontaine; Charles A. Browning, Jr., Secretary, Bellefontaine. 1st Friday, monthly.

MARION—Daniel M. Murphy, President, Marion; James A. Schuler, Secretary, Marion. 1st Tuesday, monthly, except June, July, August.

MERCER—Donald R. Fox, President, Celina; Robert F. Brashear, Secretary, Rockford.

SENECA—Harry P. Ulicny, President, Fostoria; Emmet T. Sheeran, Secretary, Fostoria. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

FOURTH DISTRICT

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FULTON—Edwin R. Murbach, President, Archbold; Robert A. Ebersole, Secretary, Archbold. 4th Tuesday, monthly.

HENRY—Tony P. Delventhal, President, Napoleon; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday, monthly.

LUCAS—Harvey C. Gunderson, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; Robert W. Minick, Secretary, Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, Paulding; D. E. Farling, Secretary, Payne. 3rd Wednesday, monthly.

PUTNAM—Joseph J. McHugh, President, Ottawa; Will W. Moody, Secretary, Vaughnsville.

County Societies' Officers and Meeting Dates (Continued)

SANDUSKY—Edwin C. Swint, President, Fremont; Paul E. Burson, Secretary, Bellevue. 3rd Wednesday, monthly.

WILLIAMS—David S. Brown, President, Stryker; Harvey F. Doe, Secretary, Edgerton. 3rd Tuesday, monthly.

WOOD—Stewart J. Smith, President, Bowling Green; Richard L. Pearse, Secretary, Bowling Green.

FIFTH DISTRICT

ASHTABULA—Walter J. Brown, President, Conneaut; Robert J. Zimmerman, Secretary, Conneaut. 2nd Tuesday, monthly.

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 125 Commerce Street, Youngstown 3. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

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CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vorhies, Secretary, Scio. Meetings quarterly.

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MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

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FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

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MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

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ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

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Hospital practice of infant feeding

Standard one-formula mixture

Normal infant nutrition requires approximately 50 calories per pound of weight. Caloric distribution should be about 15% from protein, 50% from carbohydrates and 35% from fat as formulated for the mixtures in the tables below.

For young infants, a favorable hospital formula consists of a milk and Karo Syrup mixture, isocaloric with human milk, e.g. 20 calories per ounce.

WHOLE MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Whole milk	24	480	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

EVAPORATED MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Evaporated milk	11	484	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

An infant will usually take 2 to 3 ounces more than his *age in months* at 3 to 4 hour intervals to satisfy his appetite and nutritional needs. It is psychologically unwise to force prescribed amounts. Normally, the gain in weight of 6 to 8 ounces a week during the earlier months gradually diminishes to 3 to 4 ounces a week by the end of the first year. The standard one-formula mixture not only provides adequate nutrition when vitamin supplements are added; it also provides educational opportunities to prevent feeding problems.

ADVANTAGES OF KARO® SYRUP IN INFANT FEEDING



Composition: Karo Syrup is a superior dextrin-maltose-dextrose mixture because the dextrins are nonfermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

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In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Physiopathology of the Reticulo-Endothelial System, by B. N. Halpern. A Symposium organized by The Council for International Organizations of Medical Sciences, established under UNESCO. (*$9.00, C. C. Thomas Publisher, Springfield, Ill.)* It was the aim of the symposium to bring together distinguished investigators belonging to various disciplines in order to compare and discuss results obtained in this field. Three important functions were particularly studied, namely the phagocytic activity, the metabolic function, and the role of the reticulo-endothelial system in the defense against bacterial infection. The importance of this group of cells in this system in maintaining physiological harmony and in defending the organism against pathological states was stressed throughout the symposium which provides the most up-to-date and authoritative account of the subject suitable. Dr. Charles Austin Doan of Columbus was one of the participants in the symposium. This is a book that all interested in defense mechanisms of the human body must read.

The Pathogenesis of Coronary Occlusion, by A. D. Morgan, M. D. (*$8.50, C. C. Thomas Publisher, Springfield, Ill.)* The annual number of deaths due to coronary occlusion shows no sign of decreasing. In the course of 1949 to 1952 deaths from this cause in England and Wales increased by 30 per cent as compared with 6 per cent in cases of malignant disease. In 1952 alone coronary disease was responsible for 40,000 deaths there, and in 1955 this figure had increased to over 70,000. This book provides a critical and constructive examination of Professor J. B. Duguid's thrombogenic hypothesis from the viewpoint of coronary disease. Basing his study on the large number of cases which he has examined either personally or through the records, he analyzes the cause of death in each case and gives the details of his own results. The adoption of this theory must inevitably modify the present approach to etiology and treatment; therefore it is an extremely important book for all who deal with patients having this, or threatened with this disease.

Microbial Ecology: The Seventh Symposium of the Society for General Microbiology, by R. E. O. Williams and C. C. Spicer. (*$6.50, Cambridge University Press, New York 22, N. Y.)* The papers in this symposium summarize current knowledge and views on aspects of the ecology of micro-organisms. After an introduction, a group of papers considers the effects of environmental factors that can be studied by physical and chemical methods; a second group discuss effects of interactions between microbes; further papers describe the methods of survival of fungus and protozoa in nature and the effects of higher organisms on microbial survival and distribution.

Degenerative Changes in the Sternoclavicular and Acromioclavicular Joints in Various Decades, by Anthony F. DePalma, M. D. (*$5.50, C. C. Thomas Publisher, Springfield, Ill.)* It gives a comprehensive picture of the degenerations which occur in these joints at various age levels. It clarifies the complex anatomy of the shoulder joint and permits the clinician to place the correct evaluation on the abnormalities noted.

Clinical Orthopaedics, edited by Anthony F. DePalma, M. D. (*$7.50, No. 9, 1957, J. B. Lippincott Company, Philadelphia 5, Pa.)* This publication has been renewed each year. It is designed for original articles offering significant contributions to the advancement of surgical knowledge. It consists of original monographs on subjects of outstanding orthopedic current interest.

The Surgical Management of Pulmonary Tuberculosis, edited by John D. Steele, M. D. (*$9.50, C. C. Thomas Publisher, Springfield, Ill.)* Introduction by Frederick A. Coller, M. D., a Biographical Sketch of John Alexander, by Cameron Haeght, with a series of notable contributors. This book has been written for both interns and surgeons by thoracic surgeons who were trained by the late John Alexander and by two of his close medical associates. It covers all phases of procedure currently used.

Diagnosis and Treatment of Pulmonary Tuberculosis, by Paul Dufault, M. D. (*$9.00, Second edition, Lea & Febiger, Philadelphia 6, Pa.)* This is a current book dealing with the newer things in chemical and antibiotic therapy and lung function.

Dental Health Education, by Frances A. Stoll. (*$4.50, Lea & Febiger, Philadelphia 6, Pa.)* This is the first full-length text on this subject. It correlates the important approaches to dental health education: presentation of accepted concepts, the philosophy and teaching method, application of research and dental science to dental health instruction and a sociological approach to the home, the school, the community, in solving dental problems. Dr. Stoll presents dental health as an integral part

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of community life and provides at the same time authentic information and sources for teaching and instructional material.

Oral Hygiene, by Russell W. Bunting, D. D. S. ($7.00, Third edition, *Lea & Febiger, Philadelphia 6, Pa.)* Preventive dentistry is the theme throughout this widely accepted text. It is a large edition and contains new chapters on the pathology of dental caries. Also new chapters on the role of dental hygienists and the other chapters have all been revised and rectified to bring them up to date.

Clinical Parasitology, by Ernest C. Faust, Ph. D., and Paul F. Russell, M. D. ($15.00, Sixth edition, *Lea & Febiger, Philadelphia 6, Pa.)* Changing populations, especially migration from endemic areas, and greatly increased world travel, have contributed much toward the rising awareness of parasites and tropical diseases in the United States. Northern and eastern areas are not exempt from this potential infiltration. Encouragement lies in the significant modern concept which has been introduced in this edition of Craig and Faust's "Clinical Parasitology." It provides practical suggestions and recommendations for prevention of parasitic diseases in individuals, as well as in population groups.

An Introduction To Medical Science; An Elementary Text on Pathology, by William Boyd. ($4.50, Fourth edition, *Lea & Febiger, Philadelphia 6, Pa.)* Beginners in medicine will find this book to be of great value in explaining the nature and cause of disease and the accompanying bodily changes. The author is well-known to us all for his skill in writing.

Medical Research: A Midcentury Survey, Vols. I and II, published for The American Foundation. ($15.00, *Little, Brown & Company, Boston, Mass.)* Volume I deals with principle and practice. Volume II treats of the unsolved problems in biological perspective. The importance of basic research is emphasized throughout. Since all disease represents alterations in protoplasm, research in fundamental cytology is the need.

Medicine and Man, by Ritchie Calder. (50 cents, A Mentor Book published by *The New American Library of World Literature, Inc., 501 Madison Avenue, New York 22, N. Y.)* The story of the art and science of healing.

Recent Advances in Anaesthesia and Analgesia Including Oxygen Therapy, by C. Langton Hewer and J. Alfred Lee. ($8.50, Eighth edition, *Little, Brown and Company, Boston, Mass.)* A practical summary giving the pith of anesthesia practice.

Doctor and Patient in Soviet Russia, by Mark G. Field, with foreword by Paul Dudley White, M. D. ($5.00, *Harvard University Press, Cambridge 38, Mass.)* The book is a study in the sociology of the medical profession. It is not a study of Soviet medicine; nor is it an attempt to assess its techniques.

Pharmacology and Therapeutics, by Arthur Grollman, M. D. ($12.50, Third edition, *Lea & Febiger, Philadelphia 6, Pa.)* The outstanding text has been brought up-to-date with 12 new chapters on the new drugs.

Pharmaceutical Calculations, by Willis T. Bradley, C. B. Gustafson and M. J. Stoklosa. ($4.50, Third edition, *Lea & Febiger, Philadelphia 6, Pa.)* There have been no radical changes in this well-known text.

A Manual on Cardiac Resuscitation, by Robert M. Hosler, M. D. ($5.50, Second edition, *Charles C. Thomas Publisher, Springfield, Ill.)* The author, a Cleveland physician, now gives us a manual on a lifesaving procedure where scope is enlarging.

The **Modern Drug Encyclopedia and Therapeutic Index,** edited by Edwin P. Jordan, M. D. ($17.50, Seventh edition, *Drug Publications, Inc., 11 E. 36th Street, New York 16, N. Y.)* This work with its supplementary service is well known and appreciated by 125,000 physicians and pharmacists, as a handy desk volume of references.

Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death—Volume 2, Alphabetical Index. *(World Health Organization, Geneva, Switzerland.)*

Elements of Mathematical Biology, by Alfred J. Lotka, D. Sc. ($2.45, *Dover Publications, Inc., New York 10, N. Y.)* Formerly published as **Elements of Physical Biology** has been this first book which tries to apply modern mathematics to each of the biological sciences.

Report of the Committee to Review the Medical Care Program, Publication No. 77, by the Maryland State Committee on Medical Care. (50 cents, *Maryland State Planning Commission, 100 Equitable Bldg., Baltimore 2, Md.)* A review of this program to reduce care for the indigent and medically indigent in Maryland.

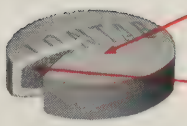
Blood Group Serology, by Kathleen E. Boorman and Barbara E. Dodd. ($7.50, *Little, Brown and Company, Boston 6, Mass.)* All aspects of the subject are treated in such a way as to give a good general picture, but concentrating on those which relate to the working of a serological laboratory.

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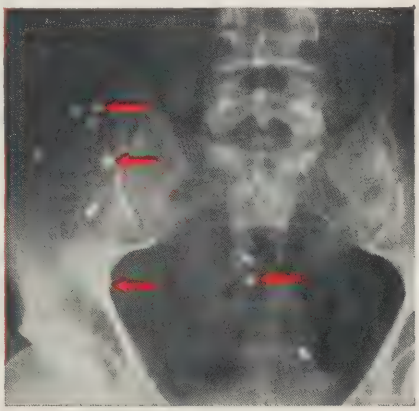
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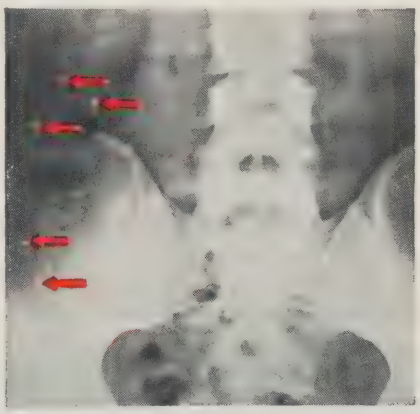
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



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8 hours Lontabs are still visible as substance of core continues to be released.



You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Nutrition Meeting

More than 500 physicians, nurses and dietitians will gather October 16 in Madison, Wis., for the fifth annual symposium sponsored by the AMA's Council on Foods and Nutrition. "Factors Involved in Formation and Disease of Bone" will be the subject under discussion at the one-day meeting to be held at the University of Wisconsin. Co-sponsors of the meeting will be the Medical School of the University of Wisconsin, the Dane County (Wisconsin) Medical Society, and the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

A highlight of the program will be a presentation by Willard Libby, Ph. D., of the Atomic Energy Commission, on atomic fall-out and radioactive stronium utilization in the human bone.

Series Plugs Health Care

Health tips for youngsters from "Dr. Dolliwell" is the theme of a new series of six transcribed five-minute spot announcements prepared by the American Medical Association. These radio platters feature a little girl who brings her doll to the family doctor for advice on various health topics, including safety, vaccinations, good nutrition and cleanliness. Medical societies wishing to book the series on local radio stations may contact the AMA's Bureau of Health Education.

Nomenclature Institute

The third in the 1958 series of regional Nomenclature Institutes will be conducted by the American Medical Association November 3-5 at the Benjamin Franklin Hotel in Philadelphia. This short course on the use of the *Standard Nomenclature of Diseases and Operations* is offered as a special service to medical record librarians and others working with the Nomenclature in the hospital, doctor's office or clinic.

Plans Group Practice Roster

The AMA's Council on Medical Service has been in the process of compiling information on group practices throughout the country and eventually plans to publish a directory of these groups. By early August the Council had information on 989 such groups located in the United States, Hawaii and Canada. Verification sheets have been sent out to those groups already on file. Physicians who practice in groups of two or more—who have not received a check sheet—are invited to send the following information to the Council: group practice name, address, office building (indicate whether rented or owned), number of physicians, and the specialties represented.

Named on Science Writers' Committee

John L. Bach, director of AMA press relations, has been named as one of five members of the 1958-59 planning committee for the National Association of Science Writers. Eugene Kone of the American Physical Society, New Haven, Conn., is chairman.

The committee agenda for the year includes preparation of a guide for the handling of press relations at all medical and scientific meetings. The committee also will consider extension of the seminar-type workshop sessions for science writers which were sponsored a few months ago by the American Medical Association in cooperation with the National Association of Science Writers. The first session was held in Syracuse, N. Y., and another in Cincinnati.

New Film on Food Quackery

How modern "medicine men" dupe the public into spending millions of dollars on unnecessary or over-priced nutritional products is the story unfolded in a new American Medical Association film.

Prepared especially for airing over local television stations under the auspices of local medical societies, the new 27-minute film—"The Medicine Man"—dramatically pinpoints the fight against quackery in the food and nutrition field.

The film singles out problems which stem from health lecturers who travel from town to town giving misinformation on nutrition as a tie-in to plugging their products of questionable merit and from door-to-door salesmen who misrepresent the value of nutritional products. The film also shows how the medical profession cooperates with the Food and Drug Administration and voluntary agencies such as the National Better Business Bureau in the crackdown on these food quacks.

Prints will be available to local medical societies after September 15 from the TV film library of the AMA.

New Neo-Synephrine®
Compound
Cold Tablets



for "Syndromatic" Control of
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Neo-Synephrine now has three complementary compounds added to its own dependable, decongestive action for more complete control of the common cold syndrome.

The "syndromatic" action of Neo-Synephrine Compound Cold Tablets brings new and greater effectiveness to the treatment of the common cold syndrome.

protection... through the full range of common cold symptoms

Each tablet contains:

for **NASAL STUFFINESS, TIGHTNESS, RHINORRHEA**

NEO-SYNEPHRINE HCl 5 mg..... First choice in decongestants for its mild but durable action and excellent tolerance.

for **ACHES, CHILLS, FEVER**

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for **LASSITUDE, MALAISE, MENTAL DEPRESSION**

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Bottles of 20 and 100 tablets:

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THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

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'Benemid' is firmly established as an *effective* and exceptionally *safe* uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

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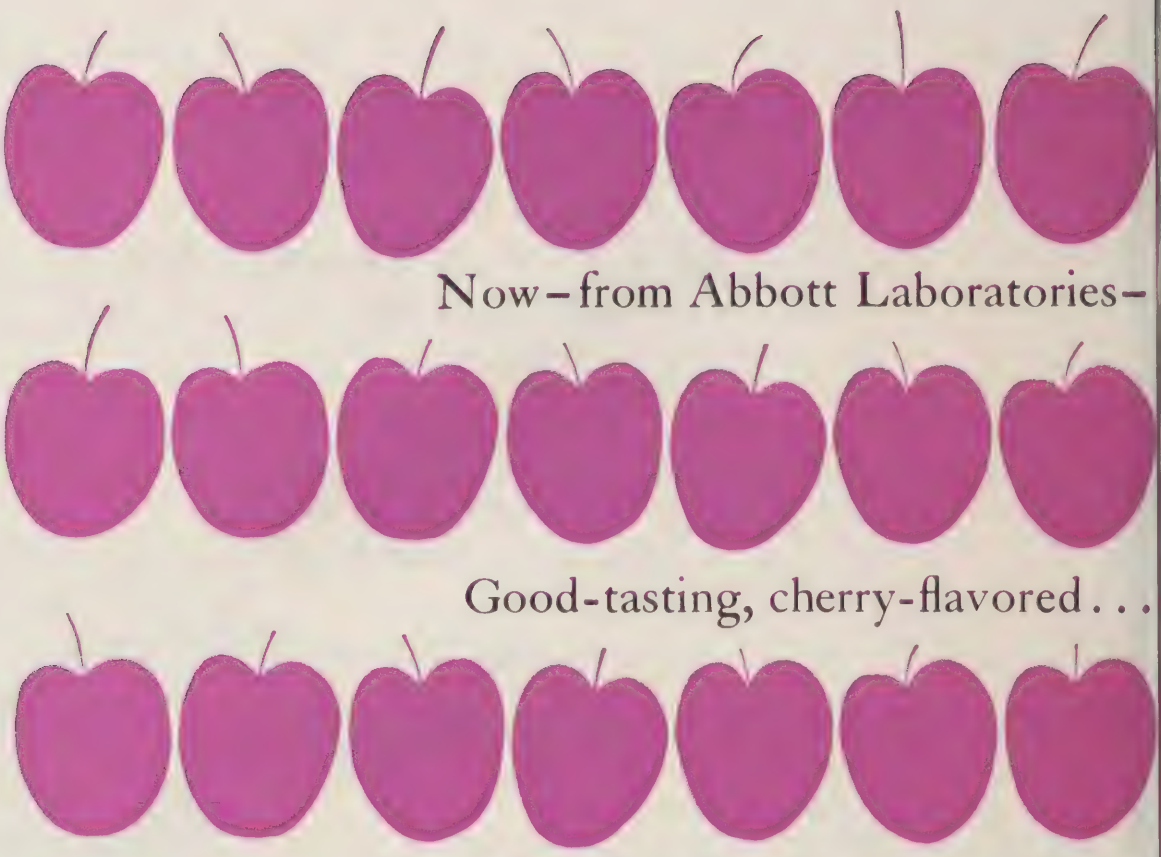
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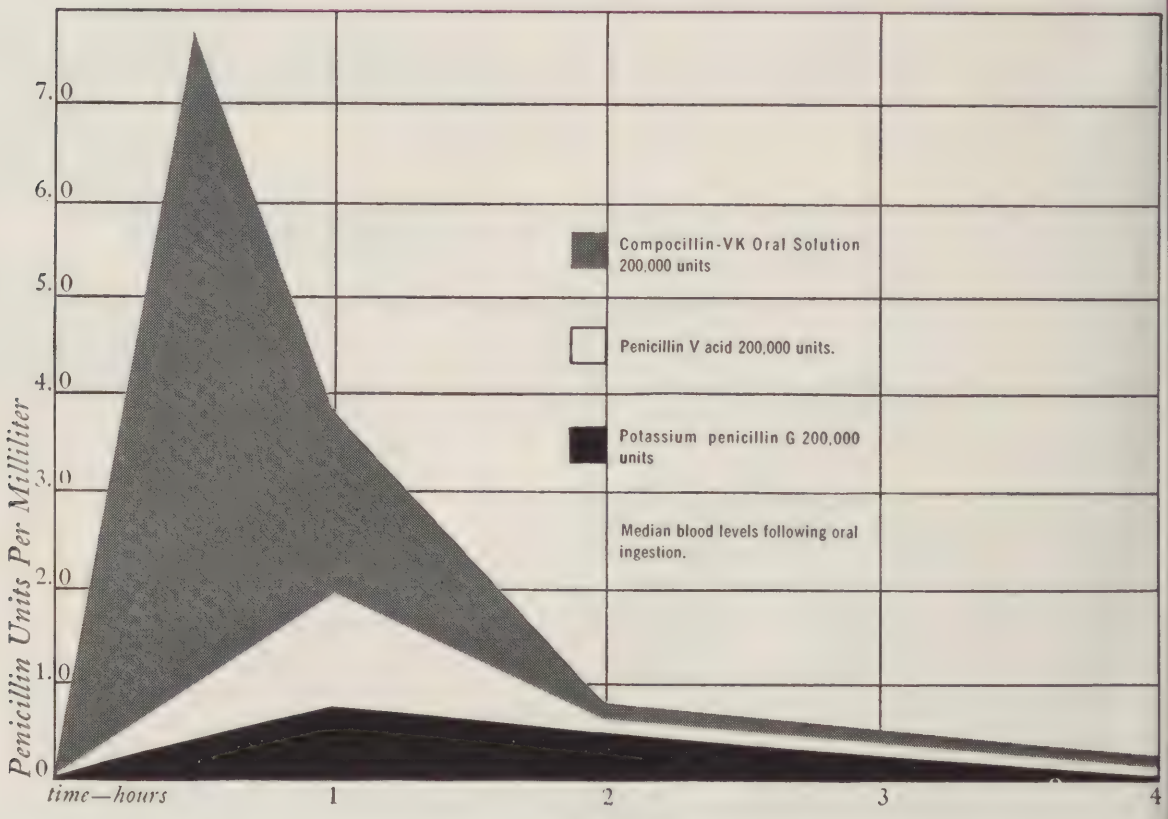
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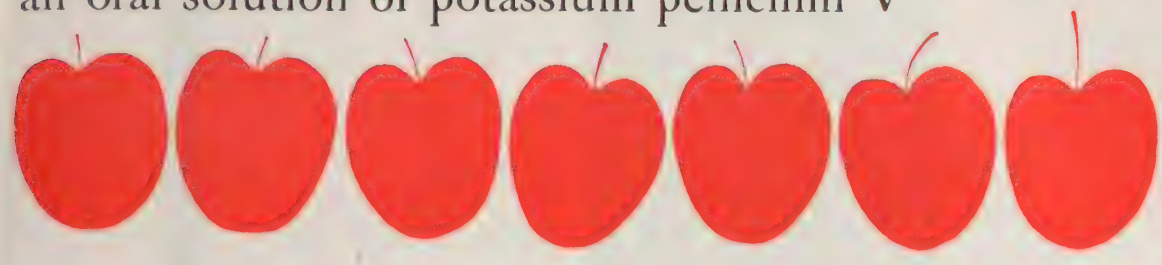
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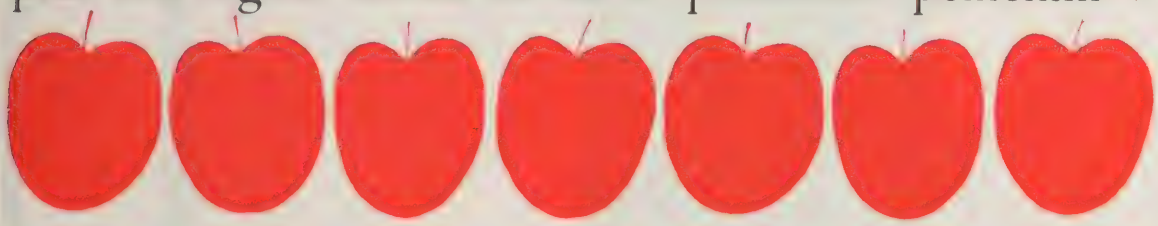




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Now, for oral administration, COMPOCILLIN-VK Granules offer you a solution of potassium penicillin V. Developed by Abbott Laboratories, the granules are dry and easily reconstituted with water.

The clear, red solution has a fresh, cherry flavor, is taste-tested and is well-accepted by patients. And they'll get those high potassium penicillin V blood levels (note chart).

COMPOCILLIN-VK is indicated for all infections susceptible to oral penicillin therapy. Also, in treating recurring rheumatic fever and in managing rheumatic carditis. COMPOCILLIN-VK may be used in counteracting complications from severe viral attacks.

The initial recommended dose: In acute infections, the range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. For young children, the adult dose may be reduced in proportion to age and weight. For prophylactic use, 125 mg. (200,000 units) may be administered once or twice daily.

COMPOCILLIN-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of the reconstituted solution represents 125 mg. (200,000 units) of potassium penicillin V. The dry granules stay stable under ordinary room temperatures. When reconstituted, the solution will remain potent for two weeks under refrigeration.

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which patients with noncalculous gallbladder disease should undergo surgery?

Essentially those who are not relieved by a prolonged trial period of medical management.
Source—Lichtenstein, M. E.: GP *16*:114 (Oct.) 1957.

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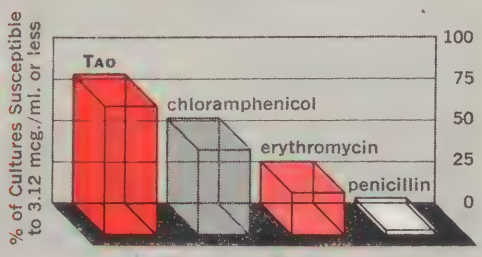
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

Social Security for Physicians . . .

Articles For and Against the Inclusion of Physicians Under the OASI Program Are Presented Before Poll Is Taken Among Members on Subject

AT the April meeting in Cincinnati, the House of Delegates of the Ohio State Medical Association adopted a resolution calling for a poll of OSMA Members on the question of whether or not physicians should be included under the Federal Social Security Program. This poll is scheduled to be held during the month of October.

The House of Delegates further directed *The Journal* to present in each of three issues (July, August and September) selected material and comments both for and against the inclusion of physicians in the OASI program. The first of this series of articles was presented in the July issue, beginning on page 868; the second in August, beginning on page 1010. This is the third in the series.

Members are advised that opinions expressed by the writers are those of the authors and do not necessarily reflect opinions of officials of the OSMA or staff members of *The Journal*.

* * *

Arguments For

By A. R. Felty, M. D.
Hartford, Conn.

Doctors Voting in Favor of Social Security 507
Doctors Voting Against Social Security 76

These were the final results of the Hartford County Medical Association referendum on Social Security conducted in September, 1956. Thus by a 7 to 1 vote, the physicians in one county of this State have unequivocally stated that they want Social Security. While these results may have jolted the faithful followers of organized medicine, they should in fact occasion no surprise, for when physicians take the time to learn the facts about Social Security, most of them will inevitably reach the same conclusions.

Well Established Law

Here are the facts about Social Security. It has been established as the law of the land for 21 years (since 1935). At the present time about 70 million workers are covered by Social Security, in fact, *virtually all* employed and self-employed workers (including lawyers and dentists). But not ALL—for employees of organizations proved to be subversive are excluded by law, and about 200,000 self-employed physicians are excluded because of the opposition of the AMA.

The spokesmen of organized medicine, notably the Board of Trustees and the Bureau of Medical Economic Research of the AMA, have steadily attacked, both in print and before the Ways and

(Continued on Page 1139)

Arguments Against

By Charles W. Pavey, M. D.
Columbus, Ohio

Last month in *The Ohio State Medical Journal* under the heading of "Arguments For Social Security" Dr. H. Fielding Wilkinson condescended to dissect some of the objections to Social Security in a grandiose manner that was obviously vastly satisfying to him, and I might add, to me. In attempting to destroy some of the more substantial arguments against the scheme he actually emphasized and confirmed them about as well as I have ever seen it done.

For example, he ridicules the idea that the Fund is bankrupt by saying that it has $23 billion in government bonds which include $3 billion in interest. Let us put this into simpler terms for easier understanding.

Example Cited

Suppose you had $8000 stashed away in a safe deposit box as a measure of security against illness, adversity or old age. A friend wants you to join him on an elephant hunt that will cost $8000. Your conscience hurts a bit about spending your security this way, so to salve your conscience you replace the money with a note signed by yourself not for $8000 but for $10,000 and bearing not 6 per cent interest but 10 per cent.

Hence, according to Dr. Wilkinson you can eat your cake and have it too. Not only do you have the fun of the elephant hunt but you made an immediate profit of $2000, and by waiting 10 years you can double your money. If you are fear-

(Continued on Page 1139)

Arguments For (Cont'd)

Means Committee of the House of Representatives of the United States, the basic principles and financial benefits of Social Security. They have advanced three main arguments.

(1) Argument—Social Security is represented as the entering wedge for socialized medicine.

Answer — *Social Security for physicians has nothing whatsoever to do with socialized medicine.* Tens of millions of American workers have been covered by Social Security for years without the advent of socialized medicine. The inclusion of 200,000 physicians in the program will not change the underlying structure of the Social Security Act. When and if socialized medicine ever comes about in this country, it will be due to other causes, not to the fact that doctors have Social Security.

Accepted as Insurance

(2) Argument—The law is actuarially unsound. Retirement benefits are described as too generous (*J.A.M.A.,* November 26, 1955, p. 1302). On the other hand, the price of survivors' insurance is declared exorbitant (*J.A.M.A.,* December 24, 1955, p. 1637). In an article in the *Journal A.M.A.* September 15-22, 1956, Drs. Webster and Coffey plunge boldly into a maze of actuarial intricacies to try to prove that Social Security is unsound, dishonest, and more expensive than regular insurance; and they even impugn the integrity of the duly elected members of Congress, and the honor of both political parties.

Answer—Actuarial soundness is a highly complicated matter which should be left to the actuarial experts. Our great life insurance companies accepted Social Security over twenty years ago. All their employees, including their presidents, their actuaries, and their medical directors are covered by Social Security. We do not hear them attacking the Social Security program.

However, since Drs. Webster and Coffey assailed the soundness of the program, their article has been analyzed by both government and life insurance actuaries, with this unanimous appraisal:—the premises on which Webster and Coffey base their arguments are fallacious, their reasoning is unsound, their conclusions are wholly erroneous and their prophecies are unjustified.

The charge made by Webster and Coffey that the cost of Social Security benefits exceeds that of ordinary insurance can be refuted by a study of the premium tables of any life insurance company. Furthermore, a careful cost study entitled "The Cost of Protection Comparable to Social Security" published in the *Bar Bulletin* of the Boston Bar

(Continued on Page 1142)

Arguments Against (Cont'd)

ful that you might not be able to repay the note at maturity you can make your wife sign it as a co-signer and you can also sign your own children's names since they are too young to sign for themselves. If at any time you should decide that the $10,000 plus interest might not be enough for your needs all you need do is increase the interest rate just like Congress votes the Social Security Fund bigger.

Shades of Ponzi!

Such is the wonderful world of H. Fielding Wilkinson and the other apologists for the Social Security Swindle. Shades of Ponzi and Alice in Wonderland!

The good doctor assures us that it is actuarially sound although he doesn't exactly offer any proof or supporting evidence for this statement beyond his own word that the size of the fund's current surplus fits the pattern anticipated 20 years ago.

Promises Made and Broken

If I may repeat a well known fact heretofore used in this discussion, 23 years ago the Social Security Act promised 33,000,000 people permanent insurance coverage after five years of payments but four years later Congress decided they should pay for 10 years instead of five.

The original act guaranteed the taxpayer that he or his estate would get his money back with interest if he did not use it up in annuities and this promise was kept to half a million beneficiaries and then arbitrarily cancelled to 33,000,000 others regardless of how they felt about it.

Political Expediences

Both the base taxable amount of pay and the rate have been altered more on caprice or political expediency than on the basis of the realities of the situation and Dr. Wilkinson would have us believe that the actuaries of 20 years ago accurately took all these things into account.

Status of Fund

On one point he is disarmingly frank and absolutely right and, it might appear, on our side of the argument. That is when he points out that any time the fund is in trouble Congress can rehabilitate it by increasing taxes. They might also solve the problem by repudiating the obligation as they did in '39.

Actually Dr. Wilkinson's statements in October of '57 were prematurely optimistic and a few months later in early 1958 it was acknowledged that the system was running in the red way ahead

(Continued on Page 1142)

Investigator

after investigator reports

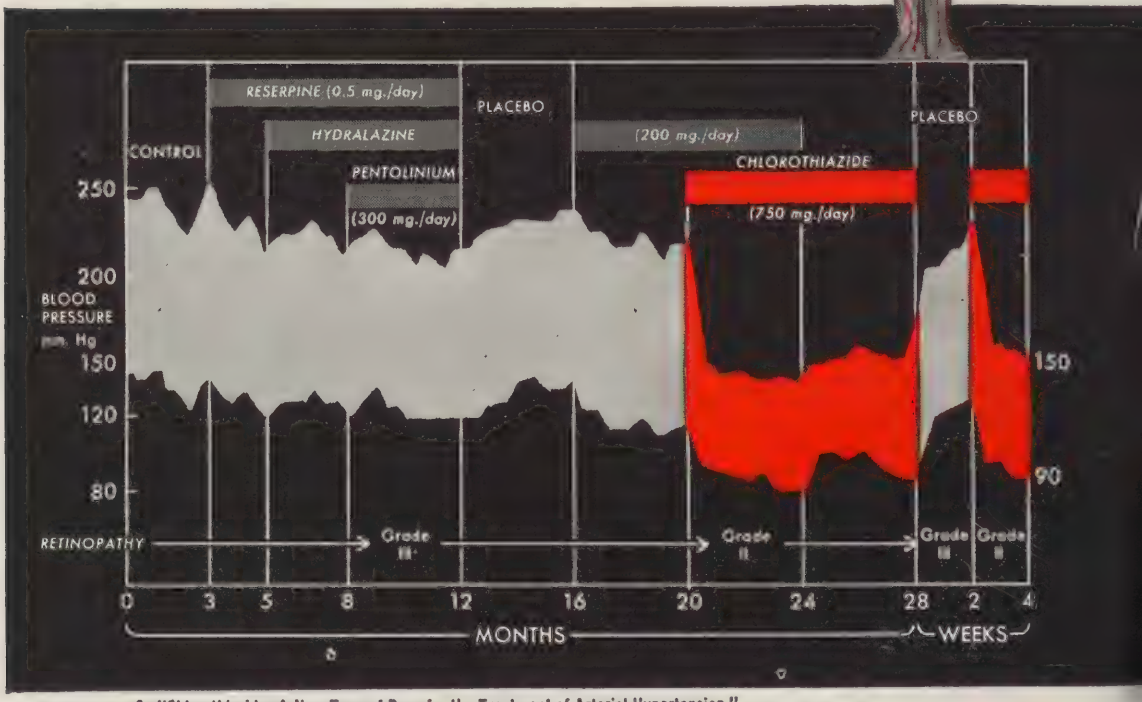
Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."



Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

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Arguments For (Cont'd)

Association, December, 1955 shows that the cost of Social Security is only one fourth to one half as much as insurance premiums, to obtain comparable benefits.

Perhaps the best answer is that of a very prominent and distinguished insurance actuary when he was asked recently for his opinion of Social Security. His answer was terse and pointed: "Get all you can of it!"

(3) Argument—The physician is pictured as a man who never retires before he is worn out. "At least 85 per cent of physicians between 65 and 72 years of age in the United States are in active practice. . . . It would not be good public policy to unduly encourage them to retire." (F. G. Dickinson, Ph. D., director, Bureau of Medical Economic Research, AMA., *Bull. Essex County Med. Soc., N. J.,* March 1955, p. 167.)

Answer—It is a debatable point whether or not a doctor should continue to work until he is worn out. However, it is significant that the established practice of hospitals today is to *require* active staff members to retire from their posts at a definite age, usually between 62 and 65. Social Security does not require physicians to retire. It merely makes it easier for them to do so if they wish.

* * *

Profession Stands Alone

From the many millions of employed and self-employed Americans who are covered by Social Security, including doctors employed by industry, hospitals, and medical organizations, we hear nothing to justify the arguments which have been used to block admission of the medical profession into the Social Security program.

The Congress of the United States is ready to legislate when physicians say they are ready to join.

Spokesmen representing the AMA stated during congressional hearings on the 1956 bill that physicians are willing to accept voluntary, but are opposed to compulsory coverage. It has been pointed out repeatedly that the Social Security statutes do not provide for voluntary coverage. (The single exception to this concerns the clergy, because the Congress is unwilling to legislate in respect to religious bodies.) It is wholly unlikely that the Congress will ever yield to a single group, the AMA, when all other self-employed groups of workers have compulsory coverage. Both the American Bar Association and the American Dental Association, which previously held out for voluntary Social Security, have now accepted the principle of compulsory coverage, and are now in-

(Continued on Page 1144)

Arguments Against (Cont'd)

of schedule. The OASI actuaries seemed confused and uncertain. At first they said tax increases in 1960 would bring the system back in balance but this was soon changed to 1965. Congress obviously has misgivings on the subject and currently a study of Social Security financing is underway.

Redistribution of Wealth

As usual organized labor is using Social Security as a means for the redistribution of wealth along Marxist lines. They are constantly agitating for an increase in the base taxable amount of income in order to compel the higher income groups to finance their plan which is already subsidized by the employer who in turn passes the cost on to the consumer.

There is no reason to believe that this taxable base will stop short of $20,000 nor that the rate will stop even at 10 per cent. Then the $20,000 per man will pay four times as much as the $5000 man for the same protection. From this we can readily see that the real reason for the drive to include the medical profession is to compel a good risk, relatively high income group to subsidize their opposite numbers. No prudent man would voluntarily accept such an arrangement from a private insurer and it's hard to see how socializing a swindle makes it any less a swindle.

Tax Increased

Recently Congress debated the question of an "across the board" $20 deduction in income tax as a remedy for the threatened recession and then promptly turned around and raised almost everyone's taxes $26 dollars a year by increasing the Social Security taxable pay from $4200 to $4800 and demonstrated once more that benefits and premiums are not matters of contract, that they can and will be juggled for political expediency and that such a tax is subject to the basest kind of abuses.

Rightfully taxes are intended as a source of revenue for legitimate and fundamental government functions but the Social Security tax was conceived as, and the income tax has become, a means for Marxist redistribution of wealth. Make no mistake about this!

Marxist Principle

If you believe in the Marxist principle "from each according to his means, to each according to his need," if you believe in the progressive graduated income tax as a means for redistribution of wealth, then it is only logical that you should advocate inclusion of doctors in Social Security.

On the other hand, if you honestly believe in free

(Continued on Page 1144)



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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

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Arguments For (Cont'd)

cluded in Social Security under the provisions of the 1956 bill.

In spite of the fact that the spokesmen of the AMA have attacked Social Security on the ground that it is actuarially unsound, they have not opposed *voluntary* coverage for physicians. But, as a matter of fact, *voluntary* coverage *is* actuarially unsound because it violates one of the basic principles of group insurance, namely inclusive coverage of the entire group. Thus the stand of the AMA spokesmen is grossly inconsistent and contradictory.

All or Nothing Attitude

The physicians in the country may choose between compulsory coverage or nothing. A referendum which asks the doctor whether he wants voluntary Social Security is unrealistic—it asks whether or not he wants something that does not exist. A referendum which asks the doctor whether he wants *compulsory* coverage is prejudicial. It is asking a "loaded" question, in using the word "compulsory" which is intended to arouse an instinctive prejudice. The word "compulsory" is redundant. The only question confronting the physician is whether or not he wants to be included in this program of old age benefits and survivors insurance.

Some spokesmen of the AMA wish a tax-deferment retirement program (as provided in the Jenkins-Keogh bills) in place of Social Security. Neither the 83rd nor the 84th Congress showed the slightest inclination to take up these measures. It is unlikely that future Congresses will either, until physicians are included with all other groups of workers in the Social Security program. Furthermore, the Jenkins-Keogh bills are not a substitute for, but a supplement to, Social Security. Discussion of the Jenkins - Keogh bills is simply not relevant to the subject of Social Security.

Many physicians have heretofore been opposed to Social Security without studying the provisions of the act.

Some Facts and Figures

Social Security provides retirement income to those over 65, and a basic security income to widows, children under 18, and certain other survivors. In addition, the 1956 law provides for those over 50 years old who are totally disabled.

A self-employed worker, earning annually $4,200 or more, will now pay $141.75 per year. This figure will gradually increase every five years until 1975, when the cost will be approximately $265. Since most physicians earn $4,200 a year, they

(Continued on Page 1147)

Arguments Against (Cont'd)

enterprise, the market economy and the importance of initiative and opportunity and the virility of America, then you must logically be opposed.

Compulsion Hit

If you will agree that no one has a right to charge merchandise to your account without your knowledge or consent then you should be willing to forego the privilege of charging your Social Security benefits to someone else's account without their knowledge or consent, someone who may as yet not have been born.

Remember any kind of socialistic or cooperative scheme of this sort that anyone wants to try, on a voluntary basis, is their own affair but forced participation is an entirely different matter.

Some counries have turned to a National Lottery as a source of revenue but so far as is known participation is voluntary. The proponents of Social Security seemingly look upon it also as a lottery but want to make participation compulsory and universal. The arguments used are the same as the excuses of an inveterate numbers player and just about as valid.

Cost Is Not Low

Most advocates of compulsory inclusion harp on the low cost of Social Security but the cost is not low! Temporarily, the price may be, for the reason pointed out by the proponents to wit: More contributors than beneficiaries.

This means that a large group is subsidizing a small group but when the so-called "low priced insurance" embraces the whole economy, when everybody is subsidizing everyone else then for all practical purposes no one is subsidizing anyone.

If I pay your insurance and you pay mine in the same amount there is no advantage to either of us and if this arrangement requires each of us to carry a type insurance not suited to our individual needs we are both losers.

Surplus Is Bookkeeping

Dr. Wilkinson points with pride to the $23-billion surplus which being in government bonds makes them a liability to the same government that regards them as an asset in one of its special funds. Hence, the $23 billion are not dollars at all but simply a bookkeeping entry but the potential claims against it are real. The 7,000,000 persons already receiving benefits will require more than $23 billion to satisfy their claims. There are almost one and one-half million others over 65 who have not as yet claimed their benefits but who are eligible.

(Continued on Page 1147)

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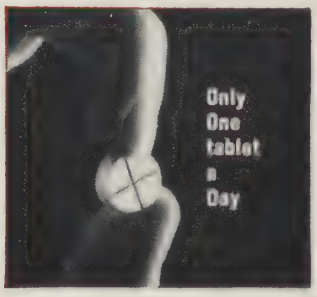
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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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*Reg. U. S. Pat. Off.

Arguments For (Cont'd)

would make these maximum payments and also receive these maximum benefits, as follows:

On retirement at 65, an individual physician would receive a monthly payment of $108.50 and when his wife becomes 65, they would together receive $162.80 a month—$1,953.60 a year. (At age 62 his wife may elect to receive 75 per cent of the amount which would be payable at age 65). If he chooses to work after 65—to quote the brochure of the Social Security Administration October, 1956, "No matter how much you earn in the year, benefit payments may be made for any month in which you neither worked for wages of more than $80 nor rendered substantial services in self-employment." Thus if he chooses to take a vacation for four months, he will receive payments during that period. Moreover, a self-employed physician over 65 would not be regarded as rendering "substantial services" if he devoted to his patients as many as forty to fifty hours a month; thus he might continue to earn several hundred dollars a month, and still be entitled to retirement benefits. At age 72 he receives each month his full retirement income, irrespective of his earnings. Income derived from sources other than "earnings" (e.g., interest, dividends, annuities, etc.) does not affect benefit payments.

At his death his widow, if over 62, receives $81.40 a month during her lifetime.

In case of his death at an earlier age, the law provides for his widow with two or more children $200 a month until the children become 18. Payments are resumed when the widow becomes 62.

At death of the insured person at any age, a lump-sum payment of $255 is paid to the surviving spouse.

Under the amended bill of 1956, the worker will receive monthly payments in the event of total disability after the age of 50.

For Young and Aged

In summary, the younger physician receives protection for his family in the event of his death. As he gets older he is protected in case of disability. At the retirement age of 65 he is privileged to receive a substantial monthly income as long as he lives, as does his widow who survives him.

Moreover, *every benefit payment under Social Security is exempt from all taxation.* In this unique respect it differs from almost every other form of income. In these days of high income taxes, this exemption provides very considerable savings.

The Board of Trustees of the AMA, in a statement regarding Social Security for physicians *(J.A.*

(Continued on Page 1148)

Arguments Against (Cont'd)

Their benefits, should they claim them, would require another $7 billion.

Potential Obligations

Next there are 25,000,000 who will become eligible at age 65. Their benefits will amount to $125 billion and finally there are 45,000,000 fully covered at present who may or may not be eligible at age 65. They represent a potential liability of from $267 to $500 billion depending on which government expert you choose to accept as an authority.

Despite Dr. Wilkinson's confidence this represents a substantial difference in actuarial estimates. This is not all. There is another lien. Survivor benefits represent a $350 billion liability covered by the same little $22 billion surplus.

Threat to Solvency

Government actuaries admit that this would be a catastrophic threat to solvency but for the fact that it is a compulsory governmental social insurance system that they assume will be perpetual in nature. What will happen should we be so unfortunate as to find ourselves in another depression with widespread unemployment deponent saith not. Neither can we predict the outcome should we have a sudden drop in birth rate, population and working force but the indications are that the political power of the older age group will insure them getting theirs.

Communist Manifesto

Right at a time when we are exhausting our resources for the "containment of Communism" abroad we seem intent on embracing the ten tenets of the Communist manifesto here at home.

Now we find even a segment of the medical profession intent on swelling the limitless bureaucracy of Socialism as though they didn't know or couldn't understand what they are doing.

But they should know. Everyone should know that the government can't reduce the cost of anything, not housing, power, insurance, transportation, medical care, hospitalization, nor anything else. What it costs it costs. If the government forces the price down below the actual cost—someone must make up the difference and that someone is you.

Anything we get without earning, someone else must earn without getting.

"Dream Castle"

The present Social Security Scheme is a dream castle built on a foundation of champagne bubbles.

(Continued on Page 1148)

Arguments For (Cont'd)

M.A., p. 1302, November 26, 1955), said, "Physicians as a group do not seek federal charity. . . . The argument that we should accept these windfall benefits because almost every eligible citizen will has little appeal to physicians. . . ." Others are more forthright and say they will not get aboard the "gravy train" with 70 million other Americans. Strangely enough, certain other opponents attack Social Security from the opposite direction. They contend it is a vast government swindle—"a Ponzi type shell game." How the American people can ride a "gravy train" and get swindled at the same time is not very clear.

Obviously the Social Security program, the fruition of 21 years of careful study, is neither a hand-out nor a hold-up. It is, in fact, one of the great social movements of this century. The citizens of the United States have underwritten the Social Security program as truly as they have underwritten the national defense program. You as a citizen have participated in underwriting it. Whether you will participate in its benefits is up to you.

In making your decision, do not let misleading words such as "socialized medicine," "compulsory," "welfare state" and other scarehead phrases confuse the issue.

The issue is simple.

Do you want this protection for yourself and your family?

Think it over and then VOTE.

* * *

By Frank P. Walsh, M. D.
Detroit, Mich.

Following is the text of an article "Why Not Participate in Social Security?" by Dr. Frank P. Walsh in the September 19, 1957 issue of the *Detroit Medical News:*

A Committee on Social Security for physicians has been formed. In a recently distributed pamphlet nine reasons are given to support the inclusion of physicians. A trustworthy expert in the insurance and investment fields was consulted. He agreed with the validity of the statements made and agreed conservatively they should be considered as sound in both categories.

The House of Delegates of the A. M. A. has repeatedly resolved that it is opposed to the compulsory inclusion of physicians as a group. I have talked to some of our local representatives in this assembly. They cannot state why this stand is taken except that it is a part of the profession's philosophy to oppose the intrusion of the Federal Government into the affairs of individuals. We

(Continued on Page 1150)

Arguments Against (Cont'd)

Everyone likes security, no one approves of poverty but it ill becomes a learned well-paid profession to clamor for a place at the public trough.

It seems that there is a well entrenched folk notion that physicians are incompetent in financial matters, an idea that is not altogether supported by facts. The very humanity of our profession may make us a bit remiss as bill collectors but indigent doctors are quite rare actually and with rare exceptions there would be little excuse for a willing, honest and industrious physician not being able to take care of himself and his family.

It hardly makes sense to burn down the barn of national solvency to get rid of the rat of old age dependency.

Wrong To Include All

An enforced savings plan for that segment of the population that cannot or will not make provision for its own old age may be justifiable even though it is subject to all of the abuses and objections previously listed but to include the remainder of the population, by compulsion, in the same scheme is indefensible and to establish dishonest rates for coverage in order to snare the unwary is downright immoral. (The people destined to pay for the shortest time will pay not only the least total amount, but also the lowest rate as the rate is scheduled to increase steadily as does the base taxable pay).

Time marches on. Change is inexorable. But there are also some eternal verities and we may be forgiven if our hearts respond to familiar sights and to some of the spiritual things that would need never change, the unyielding rock in a restless sea of turmoil and everlasting aimless probing that wears at the rock in its endless attempts at destruction.

Heritage of Medical Profession

Such has been the proud heritage of the medical profession and the men who made it. Benignly aloof, beloved and respected, not for their similarity to other men but because of their difference. Proud and independent, bold and self-sufficient they cheerfully accepted special responsibilities and received special privileges in return. They were a breed that walked humbly before God and proudly in society and then died serenely as only free men can.

Puts Questions To Physicians

What then has happened to those members of this proud profession who half-heartedly berate

(Continued on Page 1150)

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proven safety for long-term use



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Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

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1. *Friedlander, H. S.: The role of atarazics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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Arguments For (Cont'd)

are in agreement as to principle but not when present law excludes us from participation in a program we are helping to finance.

The director of the A. M. A. legal department, writing in the current issue of *Medical Economics,* considers the case against compulsory coverage by physicians. A prediction is made. 1. Congress will never authorize voluntary coverage. 2. Congress will force in the profession on a compulsory basis within five to ten years. 3. The medical profession should never ask for and never cease resisting compulsory coverage. The last statement I find difficult to reconcile with the first two.

A recent inquiry among friends and acquaintances in the profession informed me that of all who could voluntarily participate because of membership in another group, none had declined.

Facing Realism

With the philosophy behind resistance to compulsory inclusion, I am in agreement. However, we must be realists and consider our present economic environment. We may not like it but we are living in it. The trend has been established. We, as a small minority of the populace in general, do not agree with it. This is the stand that has been taken for us by our representatives in organized medicine. However, the majority of the people have decreed their pleasure. With the inevitability of inclusion becoming apparent, we would lose no more dignity than the American Bar Association has in declaring for inclusion. They polled their membership and declared the will of their majority. It is suggested our representatives follow their example. It is my belief that my fellow physicians if asked to express their opinion, would follow the pattern set by our legal friends. The foregoing generalization should be qualified to include men in medicine of forty-five years or less. The equivalent of about a hundred thousand dollars invested could barely begin to provide the amount of old age assistance benefits which are provided by the Act at age sixty-five for physicians in the age group included. Critically, I am skeptical of the soundness of the Social Security Plan when I visualize what it might cover when my children are my age. However, I would like the privilege of saving them from paying twice for my own old age assistance. I do not agree with the soundness of this trend away from the pioneer spirit of individual achievement, but I do feel that those who would like to participate should not be denied what is justly their right by the House of Delegates of the American Medical Association.

Arguments Against (Cont'd)

socialized medicine while demanding for themselves a governmental dole?

Have we become so absorbed in the pursuit of material wealth and so submerged in an avalanche of quasi science that we have abandoned all thought of understanding our environment? Are we no longer capable of recognizing socialism if it appears under another name or have we like the rest of the populace become ennervated to the point that we can embrace this foreign ideology for its lying unfullfilled promises?

If there is any truth in that old idea that the doctor was a notorious sucker for poor investments and fraudulent promotions let us hope that the current yearning by a minority of doctors for participation in the Social Security Scheme is a latter day version of the same naivete rather than a surrender of our real confidence and independence.

The medical profession will indeed have fallen upon evil days and socialized medicine, wearing seven league boots, will have come a step closer if doctors ever voluntarily surrender themselves to this degradation and madness.

God grant that something will appear to waken the medical profession from its dream world, jolt us back to reality and restore the "look of eagles."

Gastroenterological Convention Scheduled in New Orleans

The 23rd Annual Convention of the American College of Gastroenterology will be held at the Jung Hotel, New Orleans, on October 20, 21, 22.

In addition to the many individual papers to be presented, there will be panel discussions on gastric carcinoma, steroids in gastroenterology and functional disturbances of the gastrointestinal tract. There will again be scientific as well as commercial exhibits and the sessions will be open to all physicians without charge.

On October 23, 24 and 25, immediately following the Convention, Dr. Owen H. Wangensteen of Minneapolis, Minn., and Dr. I. Snapper of Brooklyn, N. Y., will again be the moderators of the Annual Course in Postgraduate Gastroenterology. The sessions will be held at the Jung Hotel and in the Auditorium of the Louisiana State University School of Medicine. Attendance at the Course will be limited to those who have registered in advance.

Copies of the program and further information concerning the Postgraduate Course and Mexico Regional Meeting may be obtained by writing to: American College of Gastroenterology, 33 West 60th St., New York 23, N. Y.



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You and Your Public . . .

Community Organizations Need and Welcome Assistance Medical Profession Has to Offer Them

MOST community organizations at one time or another find themselves contemplating or involved in projects that require medical advice.

What better source of advice can they find than that of the medical profession itself? The physician who takes an interest in these groups and makes available to them his knowledge and assistance is building strong public relations for himself and his profession.

This assistance should be given not just for the sake of public relations, but for the good of the medical profession. Last month this column called attention to three Ohio physicians honored for their long careers of community service, both as physicians and as citizens.

"Conditioned Reflex"

Such participation on the part of physician educates his fellow citizens to turn to the profession for medical advice in projects that involve questions of health.

This pertinent point is very capably developed in an address by Aubrey D. Gates, executive director, AMA Council on Rural Health. Addressing the 1957 annual meeting of the Colorado State Medical Society, Mr. Gates stated:

"Moreover, I subscribe to the slogan of the American Farm Bureau Federation that 'man's judgment is no better than his information.' There is yet much work to be done because education is a slow process."

By "education," Mr. Gates was referring to the task of intelligently presenting to the American people, in this instance particularly rural people, medicine's attitude and role in community life.

Help Is Available

He continued, "Furthermore, many organizations can and are eager to help (in this education). There are vast resources available in allies such as the Farm Bureau, Grange, Agricultural Extension Service, farm magazines, radio stations and television stations. They are waiting and willing for physicians to give leadership to worthwhile projects."

In other words, the personal participation of the physician can trigger the start of worthwhile undertakings in his community, and can guide them along the right path.

Mr. Gates made a most pertinent point here when he said, "I am not one of the people who believe that the physician in the community need necessarily be the Sunday School teacher, Boy Scout leader, or other things that lay people probably can do as well, but in health and medical care matters he is **the one** who can provide the necessary leadership and guidance in health and medical care."

Leadership Important

The importance of this leadership and guidance must not be minimized or shunted aside. Lay groups look to medicine for guidance in projects involving medical and health matters. There even may be instances where such projects involve these matters without the knowledge of the lay organizations.

If physicians fail to provide the advice and leadership in these instances, then the groups are forced to look elsewhere for such assistance. The result can be damaging to the community and to the profession, should this alternate source lack the knowledge and ability to give such advice and assistance.

American College of Surgeons Schedules Clinical Congress in Chicago

The 44th annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 6 - 10. Headquarters will be The Conrad Hilton.

Dr. Robert L. Schmitz, Chicago, assistant professor of surgery, Stritch School of Medicine of Loyola University, is Chairman of the Local Advisory Committee on Arrangements.

Major addresses will be made by Dr. Newell W. Philpott, Montreal, incoming President of the College; Dr. George J. Curry, Flint, Michigan, authority on care of the injured; and Dr. Gunnar Thorsen, Stockholm, Sweden, distinguished surgeon and writer in the field of essential body fluids.

On the final evening, October 10, more than 1,100 Initiates will be presented for Fellowship in the College, Honorary Fellowships conferred, and officers inaugurated.

Details may be obtained from the American College of Surgeons, 40 E. Erie Street, Chicago 11, Illinois.

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians: Developments in Medical and Health Fields

As result of atomic radiation leakage at the Oak Ridge, Tenn., nuclear energy plant June 16, Atomic Energy Commission has given University of Cincinnati College of Medicine a $5,600 two-year grant to compile the nation's first handbook for physicians who must treat victims of serious radiation or nuclear accidents. The college's department of radiology and radioisotope laboratory will compile the handbook.

* * *

Supreme Court has ruled that Federal Trade Commission has no jurisdiction over accident and health insurance advertising in states that have their own laws on the subject—even though such laws are not being enforced. Ruling was a blow to commission's campaign against improper advertising in those fields.

* * *

Food and Drug Administration is studying plan to print special distinctive envelopes for use by drug houses for distributing required special drug warnings to physicians. Idea is that physicians would soon distinguish the warnings from routine promotional literature—and read them.

* * *

New director of the Hill-Burton hospital construction program is Dr. Jack C. Haldeman, who helped organize the program more than 12 years ago. He succeeds Dr. Vane M. Hoge, who left the directorship to become executive director of the Chicago Hospital Planning Council.

* * *

Dr. Aims C. McGuiness, medical affairs assistant to Secretary of HEW and key figure in the Administration's program to encourage more voluntary health insurance coverage, has warned physicians against boosting fees just because their patients are covered by insurance. He pointed out that "the mere fact that an individual pays health insurance premiums does not mean that he should be expected to pay more for a given unit of medical care than someone who is not insured."

* * *

U. S. Public Health Service, Office of Education and the Children's Bureau have recommended that state and local governments substitute tuberculin skin tests for x-rays in initial screening for detecting tuberculosis among students and school employes, with x-ray as follow-up on those with positive skin tests.

* * *

Medical advisory committee has recommended to Department of HEW that nation should treble its medical research expenditures and double its physician output by 1970. Report called for 14 to 20 new medical schools and for U. S. to supply half of medical research funds—$500 million by 1970—with industry and philanthropy supplying another $500 billion. Committee believes applied safeguards could eliminate dangers of Federal control of research in such a program.

* * *

National Library of Medicine is going to get a new and permanent home. Climaxing a crusade of many years, supporters of this move have won from Congress a $7 million appropriation to construct and equip a building to house the library.

* * *

Latest report of National Institutes of Health on evidence linking cigarette smoking with cancer and cardiovascular diseases shows that of 7,382 deaths among government life insurance holders in a 30-month period, 6,203 were smokers and 1,179 were nonsmokers—a death rate 32 per cent higher for smokers, who also had a lung cancer rate 10 times higher than nonsmokers.

* * *

U. S. Narcotics Commissioner Harry J. Anslinger has voiced strong objection to a joint report of an AMA-ABA committee recommending legalized dispensing of narcotics to addicts for outpatient care, at the same time rejecting the idea of clinic therapy supported by the AMA-ABA group. Anslinger charged that "their conclusions preceded the formation of the committee."

* * *

Public Health Service reports that infectious hepatitis is running higher than expected, despite downward trend in past four years. Also, increases in 23 states range from "slight" to 300 per cent. Meningitis cases are up from 1957, diphtheria and polio are down, with a more than 50 per cent decrease in paralytic polio.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

OSMA GROUP LIFE PLAN GOOD FOR GROUPS AND PARTNERSHIPS

In our opinion each physician who is engaged in group or partnership practice should seriously consider enrolling in the new Ohio State Medical Association Group Life Insurance Plan, available to members under 75 years of age even though he may be carrying other life insurance. In fact, this is something which should be discussed by each group or partnership at once.

Why?

The answer is found in excerpts from an excellent booklet, "Prescription for Medical Partnerships." It was prepared by Dr. Charles Maertz, at the time he was medical director of The Union Central Life Insurance Company, Cincinnati, and copyrighted by that company. Incidentally the Union Central is underwriting the OSMA group life plan.

The booklet after pointing out that every member of a group or partnership should have a buy-or-sell agreement with his colleagues to bring about orderly settlement in case of death, adds these important, timely words of how to fulfill the terms of the agreement:

"Yet even the most carefully worded buy-and-sell agreement is hazardous unless there are funds with which the survivor can fulfill his obligations to the widow. A younger doctor who is compelled to pay an older partner's widow a stipulated income may be uncertain about his ability to meet these commitments if the older man dies in the near future—before the younger has developed his practice to a point where he can afford this outlay.

"**The only workable method is an agreement funded by life insurance.** It is written on the life of each partner—with the premiums paid by, and proceeds assigned to, the other. **Only in this manner may a doctor-partner be certain of his family's security if he dies.** In that event, a surviving partner can become the owner of his own policy by reimbursing the deceased's estate for past premiums paid."

Queries regarding the OSMA plan may be addressed to the Columbus Office.

TWO BILLS AND THEY'RE NOT THE SAME

The magazine *GP* says it is constantly dismayed by the realization that the average person fails to distinguish between "hospital" bills and "doctor" bills and that too many times "he rolls them up in one fat lump and loudly proclaims that 'doctors charge too much.' "

How can you meet this situation?

GP offers this solution which is well worth a try:

That physicians spend more time drawing an important line. In fee discussions they should point out that there will be a charge for "physician services" and a charge for "hospital services"—and that the two aren't the same.

"Add if you care to," *GP* says, "that since 1936 family doctor fees have climbed 73 per cent; hospital room rates 265 per cent. We hate to see people misguided and confused."

HEALTH AGENCY SURVEY SUGGESTS ADVISORY COMMITTEES

A survey of the programs and activities of 38 volunteer health agencies conducted by the Columbus Academy of Medicine produced one recommendation in particular that warrants statewide approval.

The survey report recommended that the Academy forward to each agency a list of physicians particularly interested in the disease to which the agency devotes its efforts. This list would be supplemented by advice that the physicians were available to serve on the agency's medical advisory board.

This list of interested physicians would make available to the agencies the advice and assistance of the medical profession. Who else would be more able to evaluate the work of these agencies in their efforts to combat disease?

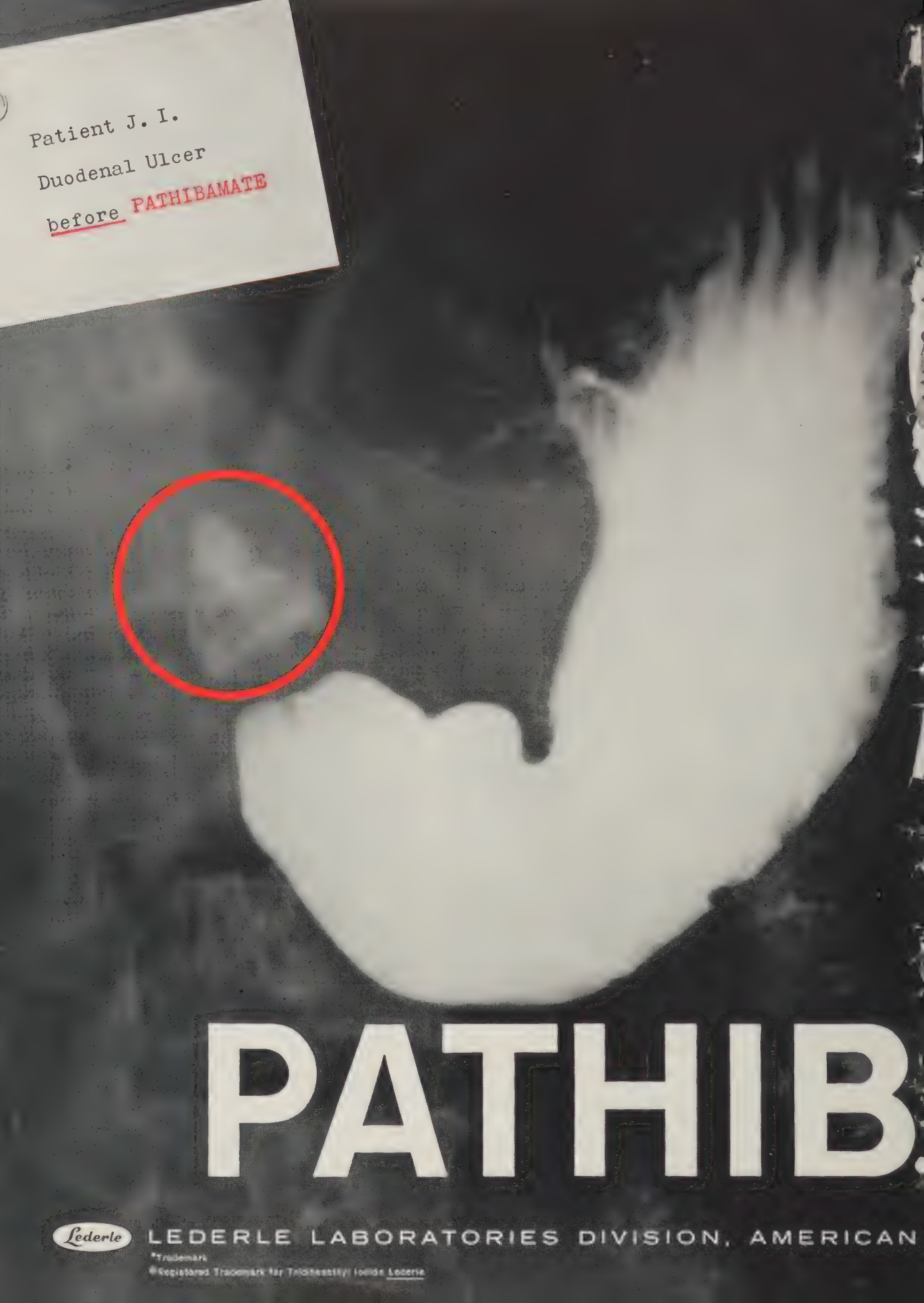
The medical advisory committee is invaluable; even indispensable. Other medical societies in Ohio that have not taken similar steps in their own localities might find it to their own interest to do so.

HERE'S WHY TAX MAN MAY BE CHECKING YOU

Here's some good advice for all physicians from the *ACADOgram* of the Cincinnati Academy of Medicine. Read it and—don't weep—but comply with the suggestions offered:

"Thousands of doctors are receiving notices for income tax audits. Reasons for questioning returns: 1. You've filed for a large refund. 2. You've failed to back up entertainment and travel deduc-

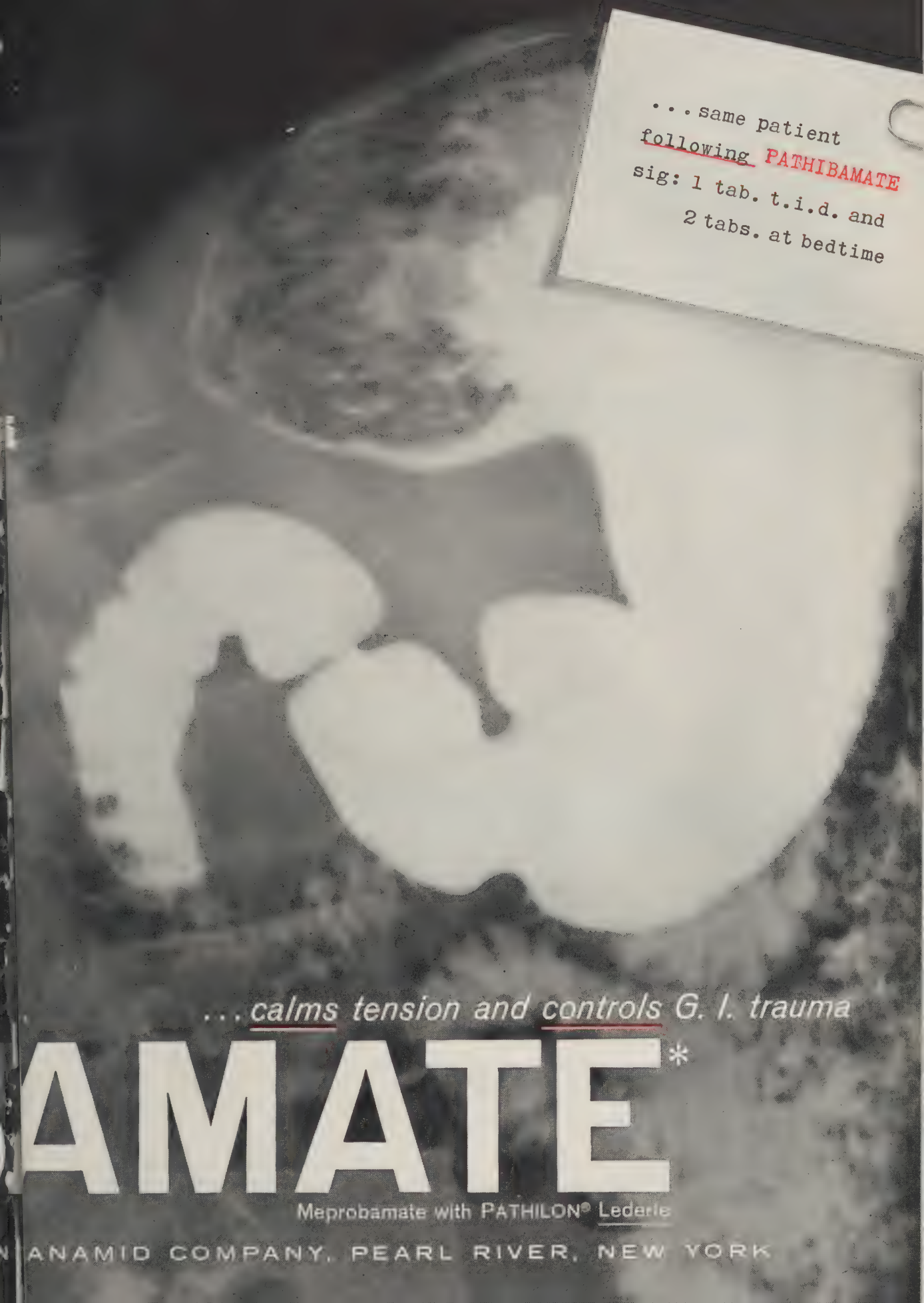
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tions with sufficient proof. 3. Your deductions for car or office expenses are notably high in relation to your reported income. 4. If you're in partnership, and your partner's return is being audited—the chances are yours will be, too. 5. Insurance companies have reported large payments made to you. Occasionally, a disgruntled patient reports the doctor to the Internal Revenue.

"Some tips: 1. Don't argue with the Internal Revenue Service auditor. 2. Present information and facts only when an item is questioned. When something doesn't seem right, consult competent tax counsel. Internal Revenue Service representatives are bound by the regulations of the Agency. You may have to take your case to the Tax Court to protect your rights."

MEDICINE'S MOST POTENT ENEMY—FRATRICIDE

In a communication published in the Public Relations department of the *Cincinnati Academy of Medicine Journal,* Dr. J. Edwin Reed offered this timely observation:

"The general practitioner is well aware that medicine's most potent enemy is medical fratricide. By this is meant the too great tendency of doctors to divide themselves into groups, in which one group hoping to be recognized as somewhat superior in some respect to another, wittingly or unwittingly divides or fragments medicine's whole strength. This results in each faction concerning itself only with its own problems and taking no interest in the vexations of the other groups. This tendency very definitely weakens what should be medicine's united front and puts the entire profession in a position to be further divided and more easily made to acquiesce to those forces which for some expediency, political or otherwise, choose to render the profession impotent."

Truer words were never written or spoken!

It is high time the profession realizes that fratricide means suicide for the entire profession anyway you look at it.

EVERY DOCTOR SHOULD BE HIS OWN LOBBY

Jonathan Wirtschafter, a second year student at Harvard Medical School, has written an article, "The Genesis and Impact of the Medical Lobby: 1898-1906." It appeared in the *Journal of the History of Medicine and Allied Sciences,* January, 1958. Reference to the article was made recently in the editorial columns of the *New England Medical Journal.*

In that editorial this statement was made:

"It was only when professional public-relations experts were employed to conduct a massive and successful campaign to influence legislation that the lobbying activities of the Association became more than mildly suspect to a considerable proportion of the population."

Be that as it may, (as a matter of fact, the enemies of the AMA made far more out of the so-called AMA lobby than the public at large) the lesson for the medical profession could be:

There will be no need for the medical profession to hire professional lobbyists if each and every physician will take it upon himself to discuss legislative matters with his own legislators; there will be no need for the medical profession to hire professional public relations experts on a mass basis if each and every physician carries on the right kind of public relations out of his own office and within the confines of his own practice.

THE MEDICAL PROFESSION AND CONTACT WITH THE PUBLIC

The "Questions and Answers" department of the *Journal of the AMA* poses some interesting developments. One doctor asked: "What direct contact does the AMA have with John Q. Public?"

The answer is too lengthy to reproduce here. It starts out with the summary that the AMA contact with the public involves three major areas —health education, public relations and public health protection through the activities of such groups as the Council on Drugs, the Council on Foods and Nutrition, the Bureau of Investigation, the Committee on Pesticides, the Council on Medical Education and Hospitals and several other similar activities.

The preparation of radio and television short subjects and developments of aids for local broadcasts on health subjects; the publication of *Today's Health,* popular health magazine; aid in preparation of health articles for popular magazines; distribution of pamphlets and other health aids to such organizations as Parent-Teacher groups, Granges, etc., are only some of the means whereby the AMA is keeping the public informed on health and medical matters.

In our opinion this procedure is multiplied 48-fold by similar programs on the part of state medical associations; and multiplied again by the activities of county medical societies.

It all boils down to one point: When a local citizen—whether it be a high school youngster seeking information for a theme, or a county commissioner—asks, "Doctor, where can I get authentic health or medical information?" you can direct him with all confidence to the OSMA or the AMA; and in many instances to your county medical society officers or committees.

in all diarrheas

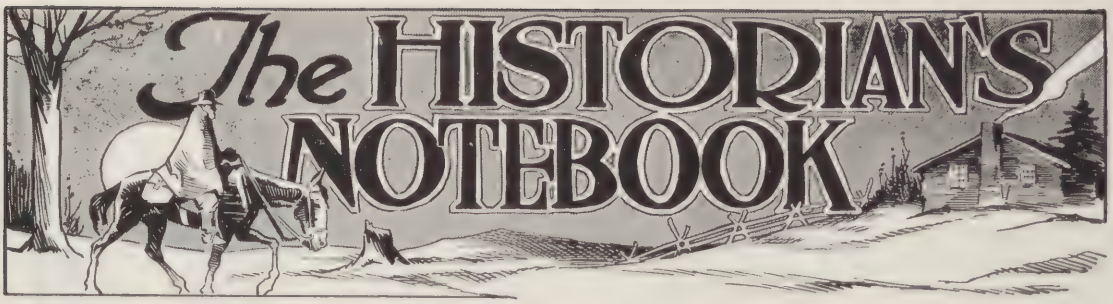
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Dr. Mary Edwards Walker (1832-1919); Charlatan or Martyr?

LINDEN F. EDWARDS, Ph. D.

PART I

DURING the winter of 1864-65 the 52nd Ohio Volunteer Infantry Regiment was encamped near Chattanooga, Tennessee. On the morning of January 6, 1865, the assistant-surgeon attached to the Regiment was found dead in his tent. Imagine the shock experienced by the officers and troops of the Regiment when it was learned that the newly assigned assistant-surgeon was none other than a frail little woman physician wearing long curls but otherwise dressed like her brother officers in blue uniform, with gold stripes down the trouser legs, an officer's greatcoat and a wide-rimmed black felt hat with a gold cord.

This fragile woman, only a little over five feet in height, was Dr. Mary Edwards Walker, a modern counterpart of the Athenian woman physician, Agnodice, who almost paid with her life for impersonating a man in order to artfully disguise her sex. Unlike that hapless maiden, however, Dr. Walker was not attempting to masquerade as a man, otherwise she would have clipped her curls and assumed a masculine name. Her adoption of male attire was simply an expression of her life-long struggle for woman's rights and dress reform.

Dr. Walker was perhaps one of the most controversial characters in modern American history, being a living example of a person having attained fame on the one hand and of having been reviled and subjected to mockery and abuse on the other.

Her Many "Firsts"

Several "firsts" are credited to her. Thus, it is claimed she was the first woman physician to practice medicine in Columbus, Ohio; she had the distinction of being the first woman ever to have received a commission in the United States Army, of being the first woman physician ever to have served on a surgery staff in any army in time of war and the first woman ever to receive a Congressional Medal of Honor; she was a pioneer in the movement for woman's rights and suffrage and is said to have been the first American woman to attempt to cast a ballot in a legal election; it is claimed she was one of the first women newspaper reporters in the United States and one of the first women, if not the first, to study law in this country; she was among the first women to mount the lecture platform and address the public, at a time when it was thought that woman's place was in the home, and she has the distinction of being the only woman ever to have been expressly granted permission by Congress to wear male garb in public. In addition to this unusual record of achievement she is credited with having invented the inside neckband of men's shirts; originating the return postcard sent out with registered mail, and suggesting a method adopted by the Post Office Department for handling third class mail.

Her High Price for Fame

Notwithstanding this enviable record, or perhaps because of it, Dr. Walker nevertheless paid

The Author

● **Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.**

A paper read at the meeting of the American Association for the History of Medicine, Williamsburg, Virginia, May 8, 1957.

a dear price for her fame and achievements. She was ridiculed by the press; she was the object of ribald humor by her fellow countrymen; members of her own sex made faces at her and even spat upon her on the streets; she was humorously dubbed a "self-made man"; she was arrested no less than a dozen times for masquerading in men's clothes; dogs were sicked upon her; boys rotten-egged her and once she narrowly escaped being tarred and feathered by a gang of young ruffians.

As may readily be expected there are several conflicting details concerning Dr. Walker's career. For instance, it is claimed that an unhappy marriage contracted early in her life was annulled, whereas, according to most of her biographers she was never married; she is said to have operated a tuberculosis sanitarium at her home in New York state; some say it was a nursing home, while others claim it was a training school for midwives; one of her bitter opponents maintained she had never been inside the walls of a medical college for the purpose of obtaining a medical education.

Her Independent, Self-willed Character

She was born on a farm located on Bunker Hill Road near Oswego, New York, on November 26, 1832. She was the daughter of Alvah and Vesta (Whitcomb) Walker, who had migrated westward from Greenwich, Massachusetts. She came from good sturdy New England stock, counting among her ancestors some of the early settlers of Plymouth Colony, including the noted Elder Brewster and the "Widow Walker." On her maternal side she was related to the Hoosier poet, James Whitcomb Riley, and to the religious iconoclast, Robert G. Ingersoll. Both of her parents taught in the local rural school which they had erected on their farm and which was the first free rural school in that section of the state.

Her father had been educated as a physician, a factor which undoubtedly influenced his strong-willed daughter to study medicine in spite of the popular prejudice against women invading the medical profession. At the age of 16 Mary was teaching school, alternating her terms of teaching with attendance at Falley Seminary in the neighboring town of Fulton, New York, where she first encountered masculine resentment by her male classmates for electing a course in human anatomy.

It was during her teaching career that she began to manifest an interest in woman's rights and particularly dress reform. She started to experiment with dress reform by wearing trousers which she partly concealed with short skirts and long coats. It is claimed that her objections to the style of women's clothing then prevalent, such as heavy skirts, artful pads like bustles and such torture instruments as corsets, were probably fostered by her father who considered these accouterments of feminine sham a menace to women's health.

At the age of 21 she entered Syracuse Medical College, which was an Eclectic institution that had been founded in 1849 and at its inception had adopted a policy of co-education, being the first medical school in the world to have adopted this policy. In February 1855 Dr. Walker was granted the M. D. degree and shortly thereafter began to practice medicine in Columbus, Ohio, where it is claimed she immediately met with marked success. One is inclined to doubt this claim because on November 16 of that year she married Dr. Albert E. Miller, one of her classmates in medical college, and they both settled in Rome, New York, to practice their profession.

As evidence of Dr. Walker's independent spirit were her insistence on being married in her reform dress; in spite of Dr. Miller's protest, of having the word *obey* stricken from the marriage ceremony and her refusal to forsake her maiden name, signing herself Dr. Mary E. Miller-Walker. It is not surprising, therefore, that a union between this self-willed woman and her rival physician-husband would not stand the test of time, even in those days when divorces were rarely sought for or granted, so that Dr. Miller soon deserted her. Being unable to obtain a divorce in New York state at that time on grounds of desertion she spent a year in residence in Iowa where she obtained her release from Dr. Miller in 1860. While there she enrolled in Bowen Collegiate Institute, from which she was suspended, so the story goes, because she succeeded in being elected to membership in a young men's literary society against the opposition of the administration and faculty. Having gained her freedom she returned to her home in Oswego, New York.

Her Contributions to the War Effort

Shortly after the beginning of hostilities between the North and South Dr. Walker volunteered her services. At first she aided Dr. Elizabeth Blackwell in organizing and training nurses for the Northern army and then transferred her activities to Washington, D. C., where she gratuitously gave her services toward the war efforts. For a time she served gratis as an assistant to the medical officer in charge of the Indiana Hospital located in the top floor of the Patent Office building and she spent considerable time visiting the hospitals in and about that city prescribing for the sick and performing operations just to be helpful. It is claimed that she even visited the battle fronts

where she administered care to the wounded in the field and that she escorted the wounded from a camp hospital at the front to a hospital in Washington. Meanwhile, Dr. Walker had applied for a commission as assistant surgeon in the Northern Army and had obtained a diploma from the New York Hygeio-Therapeutic Medical College in New York City. She even sought employment as a spy and proposed to General Burnside a plan for entering the enemy's lines. Finally in October, 1864, she was commissioned a First Lieutenant and in January 1865 was assigned to the 52nd O. V. I. Regiment as Assistant Surgeon.

While serving in that capacity she began to administer medical care to the natives behind the lines, at first being accompanied by an escort of Northern soldiers but later travelled alone. She was strongly suspected of being a spy and while on one of these missions was taken captive by some Confederate soldiers and sent to Richmond, Virginia, where she spent four months as a prisoner in Castle Thunder. The story goes that during her imprisonment because of her craving for fresh vegetables she persuaded the commissary to include occasional rations of cabbage in the food given to the prisoners. She was finally exchanged for a Confederate officer of equal rank, a fact said to have been the only instance of its kind in history.

Following her release from prison she served for a time as a medical officer at a Female Prison in Louisville, Kentucky, and later was transferred to the staff of a Refugee Home at Clarksville, Tennessee. After her resignation from the Army in June, 1865, she worked for a short time as a reporter on a New York newspaper, meanwhile attending some lectures on law given by a Columbia University professor. Soon tiring of this pursuit she returned to Washington to practice medicine.

Her Lecture and Writing Career

On November 11, 1865, Dr. Walker was presented with an executive testimony in recognition of her war services signed by President Andrew Johnson and was awarded a Congressional Medal of Honor "for bravery and valuable services in the field." Unfortunately the officials neglected to record this event in the War Department Archives and on February 15, 1917, the Board of Medal Awards ordered the medal stricken from their list. Indicative of the bitter opposition of Dr. Walker's assumption of male attire during the war period in spite of her contributions is the absence of her name in an 800 page book entitled *Woman's Work in the Civil War: A Record of Heroism, Patriotism and Patience* published in 1867 and in which the statement appears, "Those who from whatever cause donned the male attire and concealed their sex are hardly entitled to a place in our record."

An illustration of the existing prejudice of male members of the medical profession at that time against their sister members is contained in a letter to the editor of the *New York Medical Journal,* May 1867, written by Dr. Roberts Bartholow of Cincinnati, Ohio, who had also served as an assistant surgeon in the Army of the Cumberland. He bitterly denounces Dr. Walker and claims that during her examination by the Medical Board assigned to examine her qualifications when she reported for duty at Chattanooga, Tennessee, she betrayed such utter ignorance of medical science that the board found it difficult to conduct an examination. It was he who charged that "She had never been, so far as we could learn, within the walls of a medical college or hospital for the purpose of obtaining a medical education."

(To be Concluded in October Issue)

Successful One-Stage Pneumonectomy For Carcinoma 25 Years Ago

We thought it would be of interest to review some of the major features in connection with carcinoma of the lung. It is always of tremendous interest that it was only 25 years ago that Dr. Evarts Graham of St. Louis, Professor of Surgery at Washington University, performed the first successful one-stage pneumonectomy for carcinoma. All of that is necessary, because it wasn't the first pneumonectomy, it wasn't the first for carcinoma, and it wasn't the first one-stage pneumonectomy. But it was the first successful one-stage pneumonectomy for carcinoma—25 years ago, an amazingly short length of time in the history of medicine. It is also a tragic paradox that Dr. Graham died just last year of carcinoma of the lung.—Edward F. Parker, M. D., Charleston, S. C.; *J. South Carolina M. A.,* 54:207, June, 1958.

Says Reader's Digest Wrong

Dr. A. S. McCormick, Akron, historian for the Summit County Medical Society, has advised *The Journal* that a recent article in *Reader's Digest* regarding the late Dr. Halsted, Baltimore, contained a factual error. It stated that Halsted was the designer and introducer of a chart to record temperature. Dr. McCormick states that this was an error. He says that in 1883 Dr. Ebner Edgar Foltz of Akron designed the "Thermograph," now known as the clinical chart and that he sold the patent for fifty cents, the buyer profiting to the extent of $50,000.

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The Ohio State Medical Journal

Published under the direction of The Council for and by the members of The Ohio State Medical Association, a scientific society, non-profit organization, with a definite membership, for scientific and educational purposes.

Vol. 54 September, 1958 No. 9

JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

Alcohol Sensitivity in Hodgkin's Disease: (Report of Two Cases)

DUANE N. TWEEDDALE, M. D., JOHN B. WHELAN, M. D., AND FRANCIS L. BROWNING, M. D.

IN 1950, Hoster[1] first recorded the occurrence of pain in patients with Hodgkin's disease following alcohol ingestion. Since his report, over 30 instances of sensitivity to alcohol in patients with Hodgkin's disease have been recorded. (See table 1.) Because such sensitivity may become manifest as the earliest symptom of Hodgkin's disease and may be useful in following the therapeutic course of the disease, the following case reports are presented.

The Authors

- **Dr. Tweeddale, Cleveland, is Director of Laboratory, The Woman's Hospital.**
- **Dr. Whelan, Cleveland, is a member of the staffs of Huron Road, St. Vincent's Charity, and St. Ann's Hospitals; courtesy staff, The Woman's Hospital.**
- **Dr. Browning, Shaker Heights, is a member of the surgical staff, The Woman's Hospital.**

Report of Cases

Case 1: A white female, age 50, first noticed enlarged right cervical nodes in September, 1954. These were painless, and seemed at times to disappear, only to recur.

In August, 1955, she had an acute flare-up of inflammatory rheumatism, which subsided under penicillin, Gantrisin® and cortisone. Following this, the enlarged glands on the right side of her neck became very small and barely palpable. She was seen again in February, 1956, with a right lobar pneumonia. At this time the glands on the right side of her neck were again enlarged. About two weeks after her recovery from pneumonia, during which penicillin and sulfadiazine were used, her cervical glands were observed to be small, non-tender, and just palpable.

In the ensuing four months, the cervical glands again became enlarged, and a biposy was done revealing a proliferative, inflammatory, glandular hyperplasia. She then began to lose weight, become short of breath on the least exertion, had dizzy spells, a very rapid pulse, and had no appetite or pep. At this time she noticed that whenever she imbibed alcohol there occurred pain in the back that radiated into the abdomen. It was so severe that she voluntarily discontinued all alcohol. The pain commenced about five or ten minutes after alcohol ingestion. It started as a dull ache in the lower part of her back, increased in intensity until it girdled her abdomen. This made her walk stooped over, and clutch her abdomen. This lasted about one to two hours and gradually diminished. About one week before she was admitted to the hospital, she experienced the same reaction after a second dram dose of Elixir Butisol® Sodium.

She was re-hospitalized in January, 1958. Her previous slides were reviewed and a diagnosis of Hodgkin's paragranuloma was rendered which was confirmed by Dr. J. R. McDonald of the Mayo Clinic, Rochester, Minnesota. She was then given a course of deep x-ray therapy to cervical and retroperitoneal glands following which all enlarged and palpable nodes practically disappeared. About 10 days after therapy, she was encouraged to try a martini, which she did, with none of the symptoms described above.

Case 2: A white female, age 27, consulted her physician because of difficulty in swallowing, pain under the left shoulder blade after the ingestion of alcohol, and enlargement of the neck. Her symptoms had been present for three months. She stated that severe, sharp pain beneath the scapula commenced about 10 minutes after alcohol ingestion and lasted for two to three hours. Except for bilateral, shotty, cervical lymphadenopathy, the physical examination was not remarkable. A biopsy of one of the nodes revealed a typical Hodgkin's granuloma.

Deep x-ray therapy was then instituted with a good response. Her nodes became much smaller and her symptoms were partially relieved so that after alcohol ingestion she had only a dull subscapular ache. At this

point, the patient became pregnant and throughout the entire pregnancy there were no symptoms referable to her Hodgkin's disease. However, three months after the termination of pregnancy, she was readmitted to Woman's Hospital because of recurrent neck swelling, weakness, sweating, fever, and pain aggravated by alcohol ingestion. At this time, she was given x-ray therapy and nitrogen mustard. Response was only fair and a dull

TABLE 1. — *Alcohol Sensitivity in Hodgkin's Disease*

Author and Year	Age	Sex	Pain	Other Sym.	Loca. of pain	Rx Effect	Onset	Duration	Comment
Hoster[1], 1950	States has freq. observed pain in patients with alcohol inbibition. Suggests edema as cause. No report of a specific case or cases.								
Portman, U. V.[2], 1950	Noted sherry wine in gelatin dessert can cause severe pain. States reaction occurs immediately. Cough or itching may be produced. No report of case.								
Verbeeten 1952[3].	44	M	x		Shoulder and between clavicles.				
	30	M	x		Sternum	Relief	15 min.		"horror alcoholis"
	65	F		itch over entire body, neck constriction	Neck	No relief	immed.		
	27	M	x		Rt. side		immed.		
Bichel and Bastrup-Madsen[4], 1953	29	M	x	Oppression in chest. Sense of suffocation	Retrosternal, down thigh		2-3 mins.	20 mins.	granuloma type.
	26	F	x		Ant. aspect thigh		immed.	15 mins.	granuloma type.
	26	M	x		Right side of chest	Relief	immed.		granuloma type.
	24	F	x		Burning retro-sternal		few mins.	to ½ hr.	granuloma type.
	34	M	x		Lower thoracic	No relief	immed.	½ hour	granuloma type.
	28	M	x		Lumbar, sacral				granuloma type.
	52	F	x		Right arm	Relief	almost immed. to 5 mins.	1 hour	granuloma type.
	31	M	x		Across chest		immed.	10 mins.	granuloma type.
	20	M	x		Left side of chest		Shortly after		granuloma type.
De Winter[5], 1953.	37	WF	x		Coccyx	Relief	few mins.-6 mins.	1 hour	Painful areas localized the disease before it was detectable
	25	WF	x		Chest & Back	Relief			
Petch[6], 1953.	56	M	x		Hypogastric				
Hall & Olson[7]	20	M	x		Bones		Few mins. IV alcohol		Dx previously established
		M		Increased in node size and fever	Peripheral nodes				
Godden, Clagett, Andersen[8], 1956	37	FW	x		Chest & Shoul.	Relief	5 mins.		granuloma type.
	36	FW	x		Lt. neck, shoul. and upper extremity	Relief	Abrupt	10-15 mins.	granuloma type.
	35	MW	x		Low back & chest	Relief	2 mins.	15-20 mins.	
	25	MW	x		Lt. triceps			35 mins.	granuloma type.
Conn[9], 1956	—	F	x		Cervical, axillary, inguinal	Relief	immed.		Prompted Dr's dx of Hodgkin's disease
	15	—	x		Sternum	Relief	20 mins.		
	He notes two patients with Hodgkin's disease who had generalized aching, a slight feeling of ill health lasting 12-36 hours.								
Albahary[10], 1956	39	M	x		Supraclavicular	Relief	immed.	1 hour	
Tweeddale, Whalen, and Browning	50	WF	x		Back and abdomen	Relief	5 to 10 minutes	1-2 hours	Hodgkin's paragranuloma.
	27	WF	x		Subscapular	Partial relief and full relief	10 mins.	2-3 hours	Hodgkin's granuloma

Reports by Alcozer and Azzenda[11] (1955), Sandor[12] (1955), Schwarz[13] (1956), and Greiner [14] (1956) have also occurred. The articles were not available for review.

ache persisted following alcohol. However, four weeks after discharge, she was readmitted for more x-ray therapy with a more gratifying result and reported no pain after three beers.

Discussion

The commonest manifestation of alcohol-induced sensitivity in Hodgkin's disease is pain; however, generalized pruritus, cough[2], a sense of suffocation or oppression in the chest[4], increase in size of nodes and fever[7], and a generalized feeling of ill health[9] have also been noted. The pain commonly follows only minute amounts of alcohol. Indeed, Portmann[2] noted that the sherry wine in gelatin desserts can cause severe pain and our Case 1 had pain following two teaspoonfuls of Elixir Butisol Sodium. Pain usually appears immediately although a latent period up to 20 minutes may occur[4]. Duration has been noted to run from 10 minutes[4] up to one hour[4,5,10] but our patients had pain lasting for 2 and 3 hours respectively. However, the majority experience pain for 30 minutes which usually leaves spontaneously.

The pain is characteristically more severe than the spontaneous pain of Hodgkin's disease and indeed, Verbeeten[3] has referred to it as "horror alcoholis." It usually occurs in areas involved by the disease process. Thus, the upper half of the body is more often the seat of pain with the chest bearing the brunt of the attack[4,5,8,9]. However, cervical areas, shoulders, back, thigh, and rarely the hypogastrium[6] may be affected. Interestingly enough, the syndrome of pain with alcohol ingestion may antedate other symptoms of the illness[5,9]. Because of this factor, such a sequence of events should prompt careful investigation for underlying Hodgkin's disease. While such induced pain usually indicates Hodgkin's disease, there are rare instances when a patient with another disease as well as an unusual normal individual may demonstrate such a train of events[9].

The frequency of such a syndrome in a series of Hodgkin's disease cases has been reported from only a rare finding[8] up to 14 per cent of individuals[4]. Most patients were in the third and fourth decade of life with a sex ratio of approximately 1.3 males to 1 female. This is at variance with the usual distribution in Hodgkin's disease of 2 or 3 males to 1 female.[15]

The occurrence of this syndrome in a patient with Hodgkin's disease has up to now only been reported in those individuals with the granulomatous form.[4,8] Our Case 1 is unique in that it is of the paragranulomatous type of Hodgkin's disease.

Following therapy, most patients have been shown to lose their sensitivity to alcohol.[4,5,8,9,10] For this reason, in such a selected group alcohol sensitivity testing may be a valuable guide for initiating therapy, for reinstituting treatment and also may aid in locating zones for therapeutic attack. It might be added that the alcohol apparently does not affect the overall prognosis[5].

The cause for this curious phenomenon has not been satisfactorily answered. Whether edema due to altered vascular permeability,[1,2] histamine release,[4,8] or the release of a lymphogranuloma enzyme similar to Antabuse®[10] is primarily responsible is conjectural. It has been shown that the injection of histamine or other vasodilators such as intravenous nicotinic acid amide, or local application of glyceryltrinitrate ointment over involved areas does not reproduce the syndrome.[4] The only factor apparently capable of producing the syndrome is the presence of alcohol, either pure, or in combinations of innumerable palatable concoctions.

Summary

The authors have presented two cases of patients with Hodgkin's disease who demonstrated sensitivity to the ingestion of alcohol. The literature is briefly reviewed. The importance of further investigation of a patient who develops pain following alcohol consumption is stressed. The syndrome may be the earliest clinical manifestation of Hodgkin's disease. The possibile value of alcohol sensitivity as a guide to therapy should be considered.

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A Study of Chlorothiazide (Diuril®) as an Adjunctive Antihypertensive Agent

WILLIAM H. BUNN, JR., M. D.

Historical Introduction

HYPERTENSIVE patients in congestive failure may demonstrate a marked hypotensive effect coincident with drug induced diuresis. Laboratory data has been brought forth suggesting that arterial blood pressure is affected by the blood volume and degree of sodium retention. On the basis of these observations, Wilkins[1] and his associates in Boston, and a group headed by Freis[2] in Washington, set up long term studies to determine the value of diuretic agents in the treatment of hypertension.

A new synthetic diuretic, chlorothiazide ('Diuril'), was first reported in 1957 by Novello and Sprague.[3] Soon thereafter, it was demonstrated to be a potent diuretic and saluretic agent in both animals[4] and man.[5] When chlorothiazide was studied for its antihypertensive activity, it was found to be quite effective, especially when combined with other blood pressure lowering agents.

Mode of Action

All investigators seem to concede that at least part of chlorothiazide's action on blood pressure is mediated through its salt depleting action. Chlorothiazide is a more effective saluretic agent than any other known diuretic agent in the nonedematous patient.[6] Collateral evidence to support the salt depletion mode of action exists. An excess of salt intake overcomes the antihypertensive effect of chlorothiazide,[6] and conversely, salt restriction enhances its effect.[7]

Chlorothiazide may also have an intrinsic and direct hypotensive effect when used alone. Wilkins[1] and Freis[2] both demonstrate this in clinical studies. The lowering effect may be noted in patients before there has been enough time for a salt diuresis. The drug seems to manifest some specificity, not exerting any hypotensive effect on normotensive individuals.

There has been other speculation on mode of action of the drug. Wilkins[7] suggests that chlorothiazide may in some manner decrease the pressor substances in the body such as renin. Harrington[9] has very aptly demonstrated that chlorothiazide causes a decreased excretion of mecamylamine into the urine secondary to its alkalinizing effect. Consequently, it potentiates by increasing the serum level of the blocking agent. This effect, however, is only temporary. Perhaps all of these factors enter into a given situation to a greater or lesser extent. No one theory can satisfactorily explain all situations.

The Author

● **Dr. Bunn, Youngstown, is a member of the teaching staff of Youngstown Hospital Association.**

Control Period*

We have in our practive approximately 55 patients under treatment with chlorothiazide for hypertension. There is adequate follow-up in 48 cases to include them in this preliminary report. The patients ranged in age from 39 to 75 years, the mean age being 59 years. There were 22 males and 26 females included in our group. All had a primary diagnosis of essential hypertension. All but one had systolic pressures recorded at 200 or more at some time, and all had documented diastolic levels of 110 or more at some time during the control period. Only two patients had complicating congestive failure, and one had known azotemia. All blood pressures were recorded in the doctor's office in the sitting and standing positions.

During the control period, 44 of the 48 patients studied were under constant treatment with single or multiple antihypertensive drugs. Four patients had no treatment during the control period; 18 were taking reserpine alone; 13 were being treated with a combination of reserpine and hydralazine; 3 were on reserpine and blocking agents; 9 took reserpine, hydralazine, and blocking agents at some time during the control period; and the one sympathectomized patient was taking blocking agents.

The average control period for the studied group was 4.6 years. Extremes ranged from only one observation in four cases to as long as 14 years

*Blood pressure readings for this control period were obtained from the private files of William H. Bunn, Sr., M. D., and John A. Rogers, M. D.

in one case. During this control period, the patients were seen on an average of 28 visits.

Study Period

After adding chlorothiazide** to the regimen, the patients under study were followed for an average of three months, extremes ranging from one to six months. Five were observed on only one occasion, the others being seen from 2 to 14 times. The average was four visits.

Chlorothiazide was used in doses ranging from 0.5 grams to 2 grams daily in divided doses. The largest group of patients, 35 in number, were taking a combination of reserpine and chlorothiazide; three took chlorothiazide alone; nine were under treatment with chlorothiazide combined with blocking agents with or without reserpine; and one was carried on Apresoline® and chlorothiazide together. In a number of instances the dose of blocking agent or reserpine was reduced during the study period without loss of favorable effect.

In lieu of the fact that the majority of patients were extensively treated during the control period, reduction of blood pressure during the study period was quite impressive. All 48 patients showed a systolic pressure drop with an average of 23 millimeters of mercury. Forty-four demonstrated lowering of the diastolic pressure with an average of 11 mm. hg. The systolic drop ranged from 2 to 55, and the diastolic from 1 to 23. It is of further interest that 21 patients who had been previously treated and observed over adequate control periods recorded the lowest systolic and/or diastolic readings ever obtained after addition of chlorothiazide.

Side Effects

Side effects occurred in 26 patients, but were generally less serious than with any antihypertensive previously used in our practice. Only two patients (not included in the study) were unable to tolerate the drug at all. Three others had to reduce the initial dose due to side effects. The majority tolerated the drug quite well, many of them reporting a general feeling of well-being.

Of the side effects noted, a frequent symptom was the development of nocturia in six patients. To offset this group, however, there were five patients who reported the loss of previously existing nocturia. Five individuals reported sleepiness while six others voiced complaints of no pep, being tired, less drive, and laziness. There were six who had complaints referable to the gastrointestional tract with nausea, cramps, diarrhea, and even severe vomiting in two of these instances. Three patients had complaints referable to postural hypotension. There was one instance each of headache, leg aches, generalized aches, memory loss, pounding heart, excessive thirst, thrombosed retinal vein, and one bigeminal rhythm in a patient taking digitalis.

**Supplied as Diuril® by Merck Sharp & Dohme.

DISCUSSION

Review of Previous Studies

Clinical investigators generally agree that lowering of blood pressure in uncomplicated hypertension is desirable, if reasonably tolerated by the patient. Chlorothiazide has been proven to be a valuable adjunct to previously used antihypertensive agents, as illustrated in the recent medical literature. Wilkins[1] states that this drug is of real value, particularly when coupled with a ganglionic blocking agent. In a group of 23 patients studied by him, 19 responded with an average blood pressure drop of 32 mm. systolic and 21 mm. diastolic over previously treated control levels.

Freis[2] has followed a group of 73 patients who had previously been under treatment with a variety of antihypertensive agents. He found that 69 of these responded with an average further reduction in blood pressure of 16 per cent after chlorothiazide was added to their regimen. He was able to reduce the dose of the other antihypertensive agents in some instances and even entirely eliminate them in others, without sacrificing the blood pressure lowering effect.

Heider[8] added chlorothiazide to the regimen of patients who had previously been well controlled on a combination of reserpine and mecamylamine. There was further significant reduction in the blood pressure of 18 of the 23 patients so studied. In 10 of these cases the dosage of blocking agent was able to be reduced. In all clinical studies, it was obvious that previously sympathectomized patients were predictably and markedly sensitive to the hypotensive effect of the drug.

Significance of This Study

Our study deals with a group of patients followed over a long period of time. They had been treated with a variety of antihypertensive agents. Prior to the addition of chlorothiazide, the results had not been consistently satisfactory. Some of the patients experienced serious side effects. This frequently necessitated reduction in the dosage or even discontinuance of the offending agent. Some of the patients had shown initial dramatic response to the various drugs or combinations. However, eventually they would demonstrate escape effect. After the addition of chlorothiazide to the regimen, there was observed a rather constant and sometimes dramatic lowering of the blood pressure.

In contradistinction to previously reported

studies, the majority of the cases in our group were on a combination of chlorothiazide and reserpine. Although our follow-up data has been brief and not finally conclusive, the trend seems to be quite significant. There has been no suggestion as yet of escape from the effect of chlorothiazide. Although most of the patients had been previously extensively treated with other drugs, many attained a lower pressure reading than at any time in the lengthy control period.

The side effects experienced were in line with those previously reported in other studies. Postural hypertension was present in a number of our patients during the control period. This was not accentuated by the addition of chlorothiazide. A number of the patients experienced a "washed-out" feeling when their blood pressure was suddenly and markedly reduced. If therapy was continued, however, they seemed to gradually adjust to this new situation, and eventually regain their vitality despite the fact that the blood pressure remained at lowered levels. This effect could probably have been prevented by initiating chlorothiazide dosage at a lower level and gradually increasing as tolerated.

One of the most common side effects in our study was nocturia. This probably arises from the concomitant diuretic action of the drug. An equal number of patients, however, completely lost previously existing nocturia after the institution of chlorothiazide. When nocturia did occur, we found that we could sometimes eliminate this annoyance by giving the last dose of chlorothiazide in the afternoon instead of at bedtime.

Precautions Regarding Azotemia And Hypokalemia

Patients who have compromised renal function must be treated cautiously with chlorothiazide. In the case of the sympathectomized patient, addition of the drug brought about a marked hypotensive effect (blood pressure 100/70) with coincident rise of the nonprotein nitrogen from 40 to 88. This effect disappeared with temporary discontinuance of the drug, and reinstitution at a lower dosage level.

In almost every instance, our patients have been placed on daily supplements of orange juice or potassium chloride. Wilkins[10] points up the frequent measurable depletion of serum potassium in patients on chlorothiazide. He cites five instances of sudden death. These patients either had advanced coronary artery disease or were taking digitalis. He postulates that death might well have occurred due to arrhythmias which developed with lowered potassium levels. He recommends administering 1 to 4 grams of supplemental potassium. He also advises against rigorous salt restriction, as it further favors potassium excretion by the kidney.

Conclusion and Summary

We have presented a group of 48 patients previously treated with a variety of antihypertensive agents. These patients had a significantly lengthy control period.

Upon the addition of chlorothiazide to their regimens, there was realized an additional blood pressure lowering effect of 23 mm. systolic and 11 mm. diastolic.

Side effects were not serious but caution must be exercised in the treatment of patients with already compromised renal function.

Concomitant administration of oral potassium seems to be indicated.

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The Role Played by Normal Human Microbial Flora

Perhaps the time has come for us to renew our studies of normal human microbial flora and the manner in which it may shield our bodies from invasion by dangerous or harmful organisms. Surprisingly enough, little is known of the dynamic equilibrium which is maintained in our bodies by these unseen guests. Each of us harbors a population of bacteria numbering well into the trillions. They take up residence shortly after our arrival on the earthly scene, and they quickly populate our internal and external epithelial surfaces, remaining with us through thick and thin, until death closes down the boarding house and they in turn, are forced either to die or to depart. —Herbert H. Kersten, M. D., Fort Dodge, Iowa: *J. Iowa M. Soc.*, 48:240, May, 1958.

Aniseikonia — Four Case Reports

DONALD G. ALLEN, M. D.

ANISEIKONIA may be briefly defined as a condition in which one eye sees an object larger than the other. Symptoms are the usual ones for eyestrain, but an occasional patient has space disorientation, with or without other symptoms.

Three recent new cases and one old one illustrate so well the typical findings in examinations for aniseikonia that a report may be of interest.

Case Reports

Case No. 1: A 30 year old woman, office worker, never has worn glasses. Complaint: Poor vision left eye—vague discomfort. Fundi, muscles and tension normal.

Vision:

6/5 $\bar{c}$ + 0.12 ◯ + 0.25 × 80 6/5
6/12 $\bar{c}$ + 0.75 × 120 6/5
(mydriatic)
RX less + 0.12

From the beginning she reported difficulty in judging distances on her desk and also tilting of steps and floor, with the glasses. Space eikonometer examination showed that a 0.5 per cent meridional size lens × 135 O. D. equalized the right and left images. A second examination one week later gave same result. However, at this time she reported that the troubles had disappeared, therefore no size correction was given.

Case No. 2: Secretary in her middle 30's. Complaint: Car sickness, dizziness in looking back and forth at her notes on her desk. Other findings negative; reported by her ophthalmologist.

Vision:

$\bar{c}$ — 4.50 ◯ — 0.50 × 10 6/6
$\bar{c}$ — 2.50 ◯ — 1.25 × 82 6/6

Symptoms and difference in correction both suggested aniseikonia. The eikonometer, however, showed "0" size difference with repeated examinations.

Case No. 3: A 58 year old man, referred by family physician who had had similar symptoms relieved by correction for aniseikonia. Complaint: Right supra-orbital headaches—6 months, almost constant. Fundi, tension and visual fields normal.

Vision:

6/15 $\bar{c}$ + 1.50 ◯ + 0.25 × 165 6/4[e]
6/15 $\bar{c}$ + 1.50 6/4[e]
Jaeger I $\bar{c}$ + 2.50 add O.U.
Right hyperphoria 1°

This man had been wearing

+ 0.50 ◯ + 0.50 × 80
+ 0.50 ◯ + 0.25 × 100 add + 2.50, O.U., for 1½ years.

The eikonometer showed "0" size difference $\bar{c}$ 0.5% discrimination.

Glasses were prescribed:

+ 1.50 ◯ + 0.25 × 165 ◯ ½° prism base down
+ 1.50 add + 2.50 O.U. Trif.

One month later he reported complete freedom from headaches. The trouble apparently was caused by an undercorrection.

The Author

● **Dr. Allen, Cleveland, is chief surgeon, Department of Ophthalmology, Fairview Park Hospital.**

Case No. 4: A 28 year old woman, housewife. Complaint: Headaches with close work. Fundi, tension and muscles normal.

Wearing — 2.50 ◯ — 1.00 × 180
— 2.25 ◯ — 2.00 × 165

Vision:

5/60 $\bar{c}$ — 1.50 ◯ — 1.75 × 5 6/5 (mydriatic)
4/60 $\bar{c}$ — 1.50 ◯ — 1.75 × 160 6/6 "
RX given in full.

This patient was seen again three years later, and reported freedom from headaches. However, she was learning to drive and always crowded the curb when parking. The refraction was essentially the same. One would not suspect aniseikonia from the RX and it is not unusual for a new driver to have parking troubles. However, a test was made on the eikonometer. The images were equal with this magnification:

0.7% × 61 right eye
0.2% × 151 left eye

This correction was included in her prescription after a partial correction with a fitover size lens improved her space localization. At last report she had much less trouble parking.

Comment

Case 1: Illustrates the point that the eyes (brain) themselves often compensate for a definite size difference, which therefore needs no correction.

Case 2: Brings out one of the disappointments in this work. She should have had a size difference caused by the unequal correction, but didn't. I intend to try an arbitrary correction calculated from the lens powers, as she still has difficulty.*

Case 3: This case shows the value of a careful refraction and *full correction.* Aniseikonia did not enter into the picture. The ½° vertical prism may or may not have helped.

Case 4: This is a true case of aniseikonia, unsuspected because of the similar right and left corrections, and brought out by the typical space disorientation while learning to drive. Cases like this are few and far between, but are the ones that keep a person interested in the eikonometer.

*Since this was written, the calculated size correction has been tried with no relief of symptoms.

Heart Block Immediately Postpartum (Report of a Case)

N. M. CAMARDESE, M. D.,* Norwalk, Ohio

THIS is a report of an interesting case of heart block occurring in a healthy white woman, 28 years of age, and with no history of any previous heart disease. She has had five children. Her system review is negative.

Physical examination was within normal limits including blood pressure and weight.

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The patient started in labor about 6:00 a. m. At 9:00 a. m. she was given 50 mg. of Demerol,® 3/4 gr. of Seconal® and 1 cc. of Phenergan®. Atropine was specifically omitted because delivery was planned under saddle block anesthesia. The omission was to avert the much complained about dryness of the mouth. One cc. of heavy Nupercaine® was used for the saddle block. Good

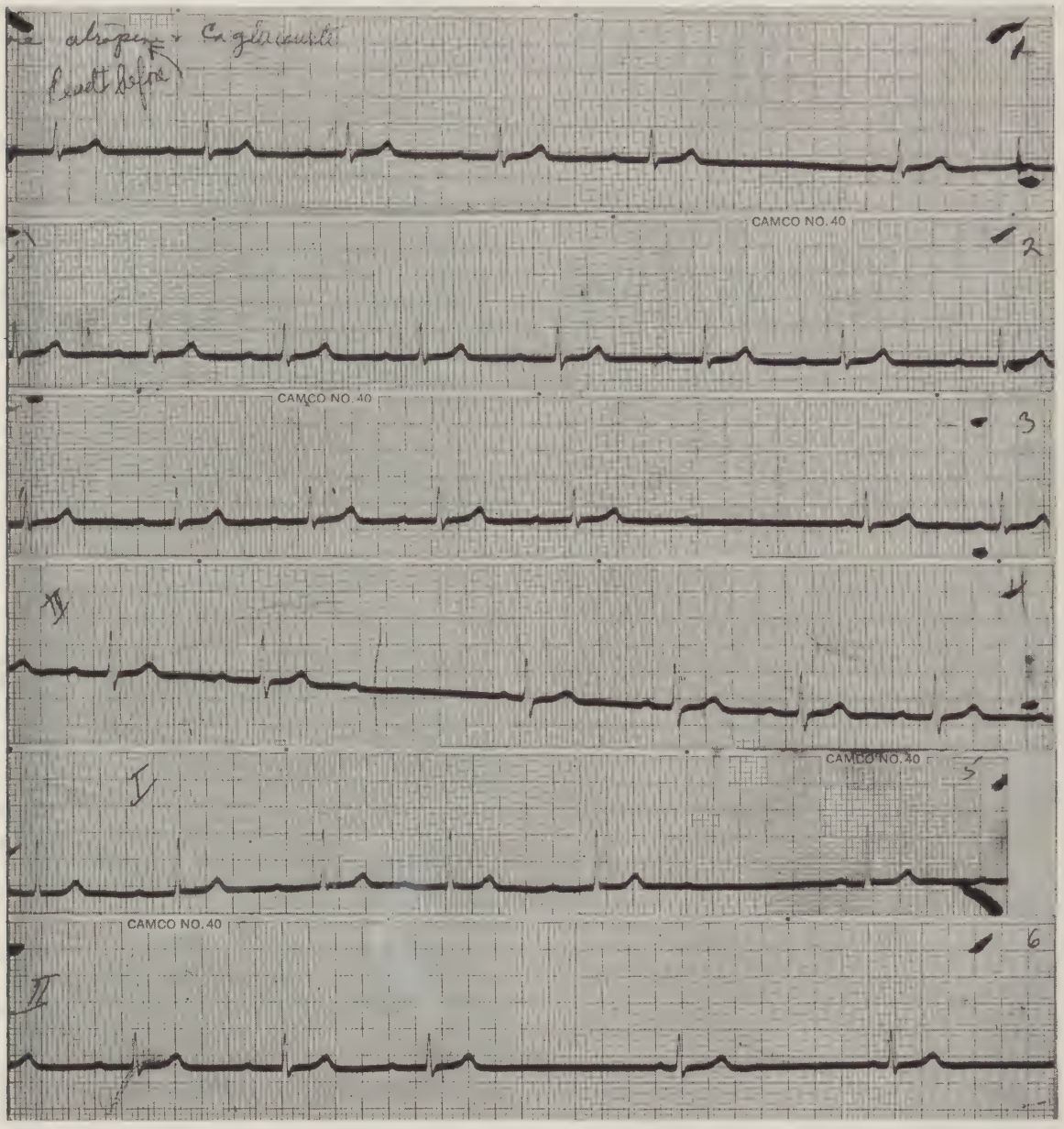


FIG. 1. Note the progressive prolongation of the P-R interval from .12 to .30 sec.. (Wenckebach phenomenon) before administration of Atropine.

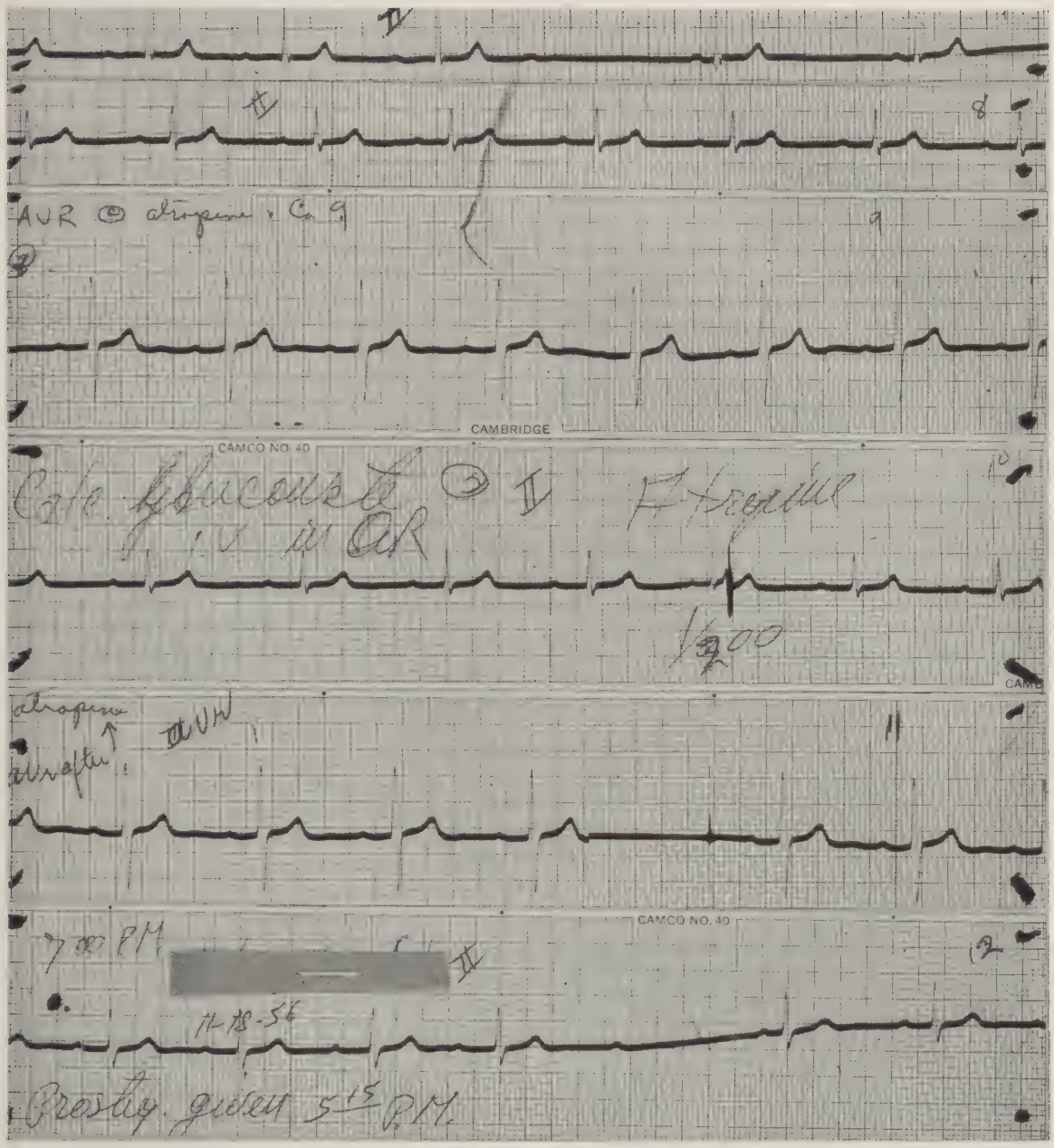


FIG. 2. After administration of i. v. Atropine (3rd tracing from top) the P-R interval is constant (.17 sec.). Block again recurs after administration of Prostigmine (bottom tracing).

anesthesia was obtained without any complications whatever. A low forceps, uncomplicated delivery was accomplished.

About one hour after delivery, patient complained of dizziness and felt like vomiting. Blood pressure was 110/70 (no drop) but the pulse was rather irregular and very slow. Not having an electrocardiograph in our little hospital at the time I rocketed to and from my office, got my electrocardiograph and the tracing showed a beautiful case of Wenckebach phenomenon with occasional complete atrial asystole and ventricular rate as low as 28.

Ephedrine ½ cc. and 1/300 gr. of atropine were given intravenously (with a running tracing). Immediately the pulse reverted to normal.

Eight hours later the patient complained of cramps and there was considerable abdominal distension. One cc. of Prostigmin® was given subcutaneously. Within five to ten minutes the heart block recurred and again it was corrected instantly with atropine intravenously.

A tracing eight weeks postpartem shows no aberrations.

Practicalities of Ileostomy Function and Management

PAUL T. CARROLL, M. D.

THE majority of patients who undergo surgery for intractable ulcerative colitis or multiple polyposis will, in the postoperative period, be confronted with the management of an abdominal ileostomy. In most cases the ileostomy is permanent and rarely if ever will continuity be restored. Following excision of the rectum the patient is left with but little choice other than to completely familiarize himself not only with the physiology of the newly formed stoma but furthermore he must learn to adapt himself socially, economically, physically, and mentally to an ileostomy life.

The patient, having sufficiently recovered from the operation, becomes not only confused but at times rather despondent as to how to conform to this altered method of bowel evacuation. Provided the stoma has been properly constructed it should work well and without difficulty. The problem now resolves itself into one of how well will the patient work with the stoma.

Instruction in ileostomy management must of necessity begin in the immediate postoperative period. Explanation concerning ileostomy function and care can be afforded by the nursing staff, the operating surgeon and referring physician. The patient can learn much from frequent interviews and conversation with trained personnel during his postoperative convalescence.

Once discharged from the hospital, however, the management of the ileostomy is now the sole responsiblity of the patient for he is for all practical purposes on his own and out of direct contact with the instructors. Having returned home the patient faces life anew. What is his adjustment to be like? How and to what extent can he become rehabilitated? How practical, how forceful, and with what attitude toward the future may he face the world before him?

It is the sincere hope of the author that the following guide written in plain, simple language may serve as an everyday reference for patients with an ileostomy about to leave the hospital. Local doctors and family physicians as well may find it of some use. The text is phrased in a subjective manner.

The physician's remarks are directed toward the patient:

"The Ileostomy, Its Function and Care"

You are about to undergo a change in your daily living. It is not a change for the worse but moreover, a change for the better. The small, tube-like projection on the right side of your abdomen is an "ileostomy." The large intestine or colon, the cause of your previous sickness and diarrhea, has been surgically removed together with the rectum. The rectum was removed because it too was destroyed beyond repair.

In order that the body wastes may be amply disposed of, it was completely necessary to bring the terminal end of the small intestine to the outside so that the products of body waste could empty by means of this newly formed "rectum" into the bag which you are now wearing. Your ileostomy then is, in truth, no more than an altered mode of having a bowel movement. It is something to which you will have to adjust to, yet it is nothing to be ashamed of.

Many people like yourself have gone through the same period of curiosity, anxiety, depression, discouragement, and have expressed the same hidden fears and despair that you are undoubtedly experiencing. Let me tell you that these people are today very much alive, happy, healthy, busy, and are enjoying life as normal citizens in every respect. Certainly, there is no reason for you not to be one of them.

Yes, there are some problems involved in the care of your new ileostomy; problems which may on occasion become serious if you are not equipped to cope with them. Please do not give up; things may seem difficult at first only to work out very well with a little energy, time, and patient understanding. Remember this much, the success or failure of the operation is entirely dependent upon your ileostomy and how it performs for you.

In the beginning the Doctor and Nurse can help a great deal in teaching you the intricacies of ileostomy function; later, however, when you are discharged from the hospital the job is entirely within your hands. Be patient and be sensible. Take a realistic attitude toward your ileostomy; learn all you can about it and it will work well for you. A properly functioning stoma will reward you with a return to normal living in every respect and you may take your place amongst

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your family, friends, and relatives uninhibited. Your life once again can be your own. Cheer up, you are going to live as a healthy, normal person.

To help you with some of the minor problems which may trouble you in the early period regarding your ileostomy and its care, the following material has been compiled. Read it over carefully and memorize it as it is your basic guide. Take it with you when you leave the hospital and study it over again at home. It has helped others a great deal and it will help you!

A. Ileostomy Care

(a) Behavior of the Stoma or Opening

The discharge from the opening will at first be runny, thin and watery-green. Later it will thicken up and become much like the consistency of normal bowel movement and will have about the same odor. An occasional watery movement should not alarm you. The stool rather tends to be thin in the morning, thickening as the day passes and as more meals have been taken. In general, foods with high residue content make the stool more solid. There may be a little blood in the stool during the first week in the form of small flecks. When the stool passes through the wall of the ileostomy the stoma may squirm or contract; this is normal.

(b) Foods Seen in the Ileal Discharge

At times the ingestion of corn, coconut, nuts, or bean pods; seeds, prunes or other high residue foods may appear at the opening. This simply means that the body does not wish to use these foods and is excreting them. If pain or distension should accompany the passage of these foods it may mean that the opening is partially blocked. It is then only necessary to insert a finger into the opening, or a well oiled, soft rubber catheter may be inserted into the ileostomy and gentle irrigations be carried out by means of warm tap water. A cupful is usually more than adequate for irrigation. The color of the stool may vary with the type of foods ingested. Remember, beets color the stool red and can be mistaken for blood!

(c) Odors

Usually the stool has the odor of a bowel movement. Some fish foods, eggs, prunes, or heavy alcohol intake may at times create a very unusual and offensive odor. There is usually no offensive odor, either from the ileostomy or the bag, which could be detected by others.

(d) Amount of Ileal Discharge

The amount and volume depend to a large extent upon the quantity and variety of food ingested. Eat as much as you like, but expect more ileostomy discharge. If the discharge becomes profuse, watery, and remains so for an indefinite period of time, it is well to get in touch with your physician. This may signify trouble!

(e) Time of Passage of Food

The time required for ingested food to appear at the ileostomy opening varies. During the day in normal activity the meal takes about four to five hours to pass, however, during sleep when all bodily function is materially slowed, 10 to 12 hours is not uncommon. Therefore, one should not be alarmed to find the ileostomy bag fairly full during the waking hours of the morning.

(f) Control

There is no control to the ileostomy as there is no muscle by which control could be initiated. The contents normally flow from the opening at a slow, constant rate necessitating wearing the bag at all times, except for periods of cleaning the bag.

(g) Emptying the Bag

It is best to empty the bag only when it becomes absolutely necessary to do so. That is, when the bag becomes full of gas, discharge, or bowel movement. Once the bag is in place it should be left alone. Frequent changing is not recommended and may do harm.

(h) Care of Skin

During the first few weeks following surgery you may have minor difficulty with skin rash or excoriation of the skin about the ileostomy. Thorough cleansing of the skin before applying the bag is a most essential prophylaxis. Be sure that the bag fits securely upon the skin. When you are confronted with a frank irritation, it is sometimes judicious to remove the bag for a three to four day period using a protective powder or cream on the skin. For this, Desitin® oinment or karaya powder is most helpful. Some people are sensitive to rubber or cement. In this respect the bag will have to be altered or a change to the plastic or Perry bag will have to be instituted.

Irrigations sometimes are of help as incomplete emptying of the ileostomy will give rise to a constant, irritating seepage which tends to digest the skin. If you are unsuccessful after having tried these varied measures, have your doctor check the bag and the ileostomy. Talk the problem over with him.

(i) Diet

You may eat any food which you desire. In general, avoid high residue foods. You will come to realize that some foods are apt to cause gas, cramps, flatus, and diarrhea—avoid them. Eat slowly, and thoroughly chew your food. Do not overeat. Avoid beer; however, an occasional cocktail is perfectly harmless. Eat between meals if

you so desire. You will gradually learn by trial and error that you can eat almost anything.

(j) **Appetite and Weight**

Most of our patients acquire a good appetite in the immediate postoperative period. The weight gain oftentimes is dramatic, and in some individuals the weight has to be controlled by dietary measures. A rapid gain in weight may at times interfere with ileostomy function. Regain your normal weight, but refrain from becoming obese.

(k) **Intake of Liquids**

You may become very thirsty—drink all of the water you desire; drink slowly and avoid iced or hot beverages. Some of our patients drink 8 to 10 glasses of fluid per day. It is fine, the body needs it.

(l) **Episodes of Pain and/or Distension**

You may experience pain, bloating, or lower abdominal distension from time to time. This is usually because of improper dietary habits or over-eating. Sometimes it is due to food particles partially blocking the opening. Finger dilatation or tap water irrigations are recommended and usually will relieve the disorder promptly.

(m) **Sleep**

In the beginning your bag may not fit properly with the tendency toward soiling the sheets during the hours of sleep. You can expect this initially, especially too when the contents are thin and watery. We advise our patients to use rubber sheeting over the mattress. Position is not important and will not prevent soiling. Get at least eight hours sleep and be in the position most comfortable to you. Turning, twisting in bed, or lying on your stomach will do no harm. Expect some soiling early; it will not last forever.

B. General Adaptation to the Stoma

You should now realize that a properly functioning stoma is in no way incapacitating. Once you have learned to care for it, it becomes a part of you as in any other organ of your body. Should you be inhibited? Are you to become a shut-in? Certainly not; not in the least! What can you do? You can do anything! Talk to another patient; ask him and see what he says. Join your local ileostomy club and attend its meetings. You will be more than surprised.

The following comprises a list of topics of interest to you in your daily living. Other patients have asked about them; here is what they have had to say:

(a) **Education and Vocation**

Patients are returning to school. One patient has become a doctor; another has attended trade school. Classes can be well attended and there has been no embarrassment; no impairment of the mind or the ability to study and do good work has ever been complained of.

(b) **Social**

The bag can be worn under any type of clothing, even under form-fitting attire, unnoticed. You should be able to attend any social function and take your place among the guests as one of them. There will be no odor, so do not worry.

(c) **Marital**

Our patients are getting married and are having happy families. Six of our patients have had normal children delivered in the same manner as any other mother. Only one of our male patients out of 40 has become impotent. One patient is soon to become a father. Coitus and sexual relationships can be carried on in normal fashion; no precautions are needed. The bag should be left on during intercourse as a rule.

(d) **Clothes**

Wear any type of clothing you desire. If helpful to you, wear a support or girdle over the bag. No harm will come from this.

(e) **Travel**

Patients may travel, ride in a car, train or bus for long distances. If you plan to be away for a long period of time stock up on extra equipment. Take along extra bags and straps. It may be judicious to take along some rubber sheeting as well. Protective skin cream and irrigation catheters may come in handy.

(f) **Athletics**

Our patients are indulging in minor sports and are enjoying them. Tennis, skating, bowling, horseback riding have all been undertaken. Bathing and hikes are permitted also. Contact sports as a rule are not advocated.

(g) **Jobs**

Work at any job to your liking. Pursue any career that you choose. One of our patients has his own garage; another is a traveling salesman; a third female patient is an active housewife and mother.

(h) **Insurance**

This has been a touchy question in the past, however, the door is open to you for all types of insurance but with some policy modifications and reservations.

(i) **Health and Accident**

You may obtain health and accident insurance, however, a rider clause may be attached to your policy.

(j) **Life Insurance**

You may as an ileostomy patient obtain life insurance, but the premium may be at a higher rate. Later as your condition remains good you may have the chance to become re-classified with the premium rate revised downward.

A Child Health Survey

Part II: The Methods by Which Addyston Met Its Child Problems

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F. W. KELLOGG, M. D., and KATHRYN D. LAVRICH, M. D.

THREE sources of information provided estimates of the health of children in the Addyston survey. Examinations of children in the school were made by nurses and doctors, conferences were held with teachers and parents and a house to house canvas was carried out over a three month period. The techniques employed and the defects found have been discussed in a previous report.[1] The abnormalities of health which occurred with the greatest frequency were those usually encountered among children of middle economic groups. Seven of these most common conditions, dental caries, eye and ear defects, heart disease, malnutrition, tuberculosis and behavior disorders were selected for further evaluation and especially in regard to the facilities in the community for their diagnosis and care. This report summarizes that part of the survey.

The Dental Situation

The incidence of dental caries, as discovered during the doctor's examination seemed high for this age group. More than 50 per cent of the children had readily apparent cavities. Had a dentist examined the teeth carefully with mirror and probe, he would have found many more children who needed attention.

No dentist resided in Addyston and only one in Cleves, the adjoining town. To secure dental care the children of this area had to go a long way to see a private dentist, and if clinic care was obtained, the distance was about 25 miles, the time for transportation alone being two to three hours.

Immediately following the survey the Addyston health committee inaugurated a program for dental care which might be at least partly self-supporting. Through The Children's Dental Care Foundation of Cincinnati a dental chair and equipment were donated. Room for the dental equipment was provided at the school and the additional funds for installation were secured from parent-teacher groups, an industrial plant and the Cincinnati groups. More difficult at the onset was the staffing of the clinic, but a practicing dentist offered a half day each week and a small sum was provided for this part time work.

This problem of the establishment and staffing of a Dental Clinic for children was discussed frequently by lay and professional groups. They concluded that guidance and supervision should come from the dental profession but the responsibility for support seemed to lie with tax supported institutions such as the village or county, or with charitable organizations concerned with health problems of children. A third procedure, favored by most of the committee, was the reduction of overhead costs to a minimum so that professional services and supplies might be paid for by the patients themselves.

Eye and Ear Defects

There were 46 children (14 per cent) of the group who had eye disorders, usually defective vision, but occasionally squinting or ptosis of the lids. A total of eight children (2 per cent) had defective hearing or chronic infection of the ear. Almost every one of these children required the care of specialists who had offices or clinics in Cincinnati. There was no evidence of inability on the part of the patients to secure needed consultations and the nursing and teaching staffs had been very cooperative in encouraging the pupils to follow the medical instructions. There seemed to be

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no need for the visiting physician or survey group to add to or change this program.

Heart Disease

Information regarding heart disease and rheumatic fever was obtained from three sources: the physical examination, questionnaires sent to parents, and from medical data collected previously by teachers and nurses of the school. Examinations were made with the pupil in erect and in recumbent positions. Whenever questions arose regarding the nature of a murmur, more than one physician examined the child.

Among the group of 322 children ranging in age from 5 to 16 years, only one child had a definite loud murmur due to an abnormality of the heart, in this case a congenital heart deformity. This child was under the care of his private physician and was making regular visits for observation. The occurrence of one child with a definite murmur among 322 children was exactly the rate (0.3 per cent) expected from previous surveys made of school children in Cincinnati a few years ago.[2]

In addition, there were 36 children (11 per cent) with heart murmurs which were faint and inconstant, all diagnosed as functional or inconsequential murmurs and not representative of abnormality of the heart. Since such murmurs occur frequently in children and may be a cause of unnecessary alarm by patient and their parents, the observation was recorded on the patients' charts but no mention of heart disease was made to the children or their parents. The children will be kept under observation but no treatment or restriction of activity was advised.

Finally there were four children who had a history of rheumatic fever at some previous date but had no residual heart damage. One of the children had been a patient at The Cincinnati Children's Hospital and was being followed there at regular intervals and was receiving prophylactic treatment to prevent recurrence of the disease. Others had less definite histories and were in excellent health. Since the information of the symptoms came from the parents, the children were referred again to their doctors and efforts will be made to have them observed regularly by these physicians in their offices or clinics. (Table 2).

The Nutritional Problem

There were 25 children (8 per cent of the group) who were considerably underweight or overweight (below the 3rd percentile or over the 90th percentile on the Anthropometric chart of the Boston Medical Center). The 15 who were unusually thin were mostly boys who were alert and active and had apparently been leading normal, healthy lives. To be certain that there was no organic disease in the background, one physician of the survey group returned to the school on several occasions to examine these children more carefully; to check their medical records for evidence of previous disease; to interview their parents and finally to test the urine for albumin and sugar, and the blood for evidence of infection or anemia. No abnormalities were discovered. The nurse planned to make regular measurements of height and weight to observe their trends over longer periods of time.

TABLE 2.—*The Incidence of Murmurs Among 322 Addyston Children*

Congenital Heart Disease	1
Functional, inconsequential murmurs	36
Total	37
History of rheumatic fever, but no murmur or heart damage	4

The 10 overweight children were mostly girls of pre-adolescent ages. At first the staff planned nothing for this group but upon learning that some of the children were interested in discussing diets, arrangements were made for the chief dietitian of the Cincinnati General Hospital and one of her student interns to meet with the pupils. This activity was carried out as a project of the Community Nutrition Section of the Cincinnati Dietetic Association and it was interesting to note that 18 children, more than the number selected by the doctors, asked to be included. The conference was devoted to a discussion of balanced diets emphasizing the "basic seven" foods, with added suggestions for gaining or losing weight. Charts were given to the pupils, a display card was presented to the school and check lists of the basic seven foods were sent to the nurse for distribution.

Tuberculosis

Examination for tuberculosis included routine patch tests, measurements of the height and weight of the children for evidence of malnutrition and occasionally examinations of the chest, although very little reliance was placed on the presence or absence of abnormal lung sounds as diagnostic signs of tuberculosis in children. Questionnaires to parents, nurses and to teachers sought information regarding tuberculosis in families and unusual symptoms of fatigue or malnutrition among parents or children.

Thirteen children had positive tuberculin patch tests. All but three had been known as positive reactors by parents and the nurse at school. X-rays had been made of the children's chests and the course of the infection had been followed regu-

larly in the local chest clinic, a facility Addyston is fortunate in having.

One child with a newly discovered positive test caused immediate concern to the parents and before the day was over, the mother had taken the child to Cincinnati for an x-ray of his chest, which was reported free from any sign of active infection.

An additional 15 children were underweight as determined by comparing their measurements with standard charts. Others were described by parents and teachers as sleepy, inattentive and frequently tired. When these children were examined at a later time, no evidence of tuberculosis could be detected.

The rate of positive tuberculin reactors was about 4 per cent, a figure midway between the 0.7 per cent found in suburban Cincinnati and 7 percent found in the congested basin areas of the city.[3] Of considerable importance was the ease with which the tuberculin patch test was performed and its effectiveness in selecting children and families for further investigation.

Behavior Problems

There were 19 children (6 per cent) reported by the teachers to have abnormalities of behavior. Many of the disorders were mild and were manifested chiefly by flagging interest and energy in school work. Others had deep seated problems of adjustment and behavior, often associated with disturbed home environment. A few of the families of the delinquent children were known to social agencies in Cincinnati, but none of the children was receiving any psychiatric guidance. The survey staff was undecided about the advice to give the community regarding treatment of this problem.

It seemed likely that this group of children had been living for such a long time in poor home environments, under conditions of broken or misguided family life, that it would not be easy to effect any changes in behavior unless the families experienced a definite desire for help and guidance. It was suggested that a program devoted to guidance of the brighter children of the school to encourage them to continue school work or to secure specialized education might bring greater rewards than attempts to lift those of lower levels to acceptable social standards.

As a trial project, one family containing delinquent members was investigated thoroughly to search for causes of abnormal behavior of the children. Using such information the survey group planned to meet with the teachers and discuss the problems of the specific children and if possible, to make some general deductions of policies or plans to follow in developing a program of mental hygiene for the community.

Under the auspices of the Adolescent and Developmental Clinic of the Cincinnati General Hospital, a social investigator, a psychologist and a physician interviewed and examined the patient and his family and presented their findings for group discussion. One result of the conference was an increasing awareness by the family that help for behavior problems was available, and a second result was an insight into some of the conflicts existing within the community.

An important step taken by the school was the appointment of an additional teacher in order that more time might be spent by all of the faculty in caring for minor individual problems arising in the classrooms. More opportunities for conferences between teacher, nurse and doctor were advised but limitations of time and money have made it impossible so far to carry out this plan.

Reorganization of summer work opportunities and recreation activity was undertaken by the community and even if results prove to be meager at first, the interest of the community has been aroused and the attention of the community has been focused on this aspect of child health.

Discussion

The Addyston Survey was undertaken to determine the specific health problems of the children in a distant suburban area. The community was well aware of the general nature of its hygenic situation but the survey brought into sharp focus some of the most pressing problems and suggested an immediate course for correction. The presence of an intelligent health committee, eager for action, made it easy for the suggestions to grow quickly into definite plans.

Most of the physical abnormalities of the Addyston group were similar to those of children of other communities. These patients were receiving good medical care. Facilities for treating dental decay and behavior disorders were inadequate. Within a short time, however, a dental clinic had been established by the town and steps had been taken to help some of the children with problems of behavior. The survey showed that environmental factors existing in the community might be responsible for deep rooted causes of maladjustment but that first steps towards help for the children had been taken and a long-term program of mental hygiene might be built on these foundations.

The survey also indicated that repeated medical examinations in school may not be necessary in many communities. This suggestion has been made in previous reports.[4, 5, 6] Most parents in Addyston found their way to private physicians or clinics for illness and obvious physical defects of their children. The school nurse had checked the children

for immunization, vision, hearing, nutrition, tuberculosis. The need for control of serious communicable disease in the school has almost disappeared.

The school physician today might spend less time in making repeated physical examinations of children, but devote more attention to the supervision of routine testing programs, and to the studies of community problems, family cultures, housing and recreational facilities as they affect the health of children. The school furnishes an excellent center of study because there the children can be observed, the teachers may be consulted and the parents invited in for conferences.

Conclusions

1. The health of Addyston children compared favorably with standards of larger, more urban populations.

2. Adequate medical care was available and most of the Addyston families were using it satisfactorily.

3. There were several health activities which Addyston is very fortunate in having such as:

   (a) An active and effective health committee.
   (b) A school whose teaching and nursing staffs are intensely interested in the health problems of the community.
   (c) An infant welfare and a "chest" clinic.
   (d) The Lower River Nursing Association.

4. The school survey exerted its greatest influence in spheres other than the detection of physical defects, namely as:

   (a) A stimulus for parents to carry out recommendations made previously by their physicians.
   (b) A goal for the completion in school of routine testing of hearing, vision, tuberculin reactions, immunization, weighing and measuring.
   (c) A review of the total health needs of the community to see what programs should be strengthened and what ones might be discarded.

5. One of the special health problems which confronted Addyston was the high incidence of dental caries. The survey urged the establishment of a local dental clinic which was started immediately and is now operating regularly.

6. Another problem faced by Addyston was the large number of behavior disorders among the children of school age. A continuous program suggested by the survey staff consisted of:

   (a) The minute study of a few of the children most seriously maladjusted.
   (b) Several conferences each year with the teaching staff to plan methods of treatment and prevention.
   (c) Communitywide efforts to stimulate physical, manual or intellectual achievements; vocational skills; health social activities.

The school responded at once by reducing teacher loads, thus encouraging individual teacher-pupil conferences and special assistance programs.

7. The majority of physical disorders of school children are detected by measurements of vision, hearing, height and weight and tuberculin testing. Reports from parents and teachers give the information regarding abnormal behavior problems of the children. Since the school nurse can carry out many of the foregoing procedures, the school physician might be most useful in serving as a health adviser, supervising the above tests and fact finding programs, and studying health needs of children against the background of family influence and community life.

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Good Data on Morbidity Needed In Current Health Studies

It is a remarkable fact that for knowledge of health we rely largely on information about death.

National mortality rates have been in existence for more than a century, but there are few good data on morbidity, and other more direct indices of health scarcely exist. Yet mortality statistics are in many respects an unreliable guide to the incidence or social consequences of diseases; for example, they would lead us to overestimate the significance of cancer of the lung and to greatly underestimate the significance of the common cold. Unfortunately it is easier to recognize the difficulties than to remedy them.

Death is a single event for which an immediate cause can frequently be given. Many episodes of sickness meet neither of these requirements, and it is not surprising that it is only for a group of notifiable infectious diseases that continuous records are available for any considerable period.—*West Virginia M. J.,* 54:171, May, 1958, as abstracted from *British Medical Journal.*

LEDERLE LABORATORIES

A Division of AMERICAN CYANAMID COMPANY

INTEROFFICE CORRESPONDENCE

Pearl River, N. Y. 7/18/58

OFFICE DATE

TO: Advertising Department COPY TO:

ATT'N: J. D. Roberts

FROM: C. K. Howe, Sales

Jim --

Here's a question a number of our detail men have tossed at me. Why doesn't Lederle's advertising for ACHROMYCIN V Tetracycline play up higher, faster blood levels the way so many of our competitors do?

As you know, new laboratory studies show pretty conclusively that ACHROMYCIN V is unexcelled in this department.

How come we haven't turned on the heat in our ads?

C. K. Howe

CKH:ls

LEDERLE LABORATORIES

A Division of AMERICAN CYANAMID COMPANY

INTEROFFICE CORRESPONDENCE

Marked OK JDR

Pearl River, N. Y. 7/21/58

OFFICE DATE

TO: Sales Department COPY TO:

ATT'N: C. K. Howe

FROM: J. D. Roberts

Charlie --

Sure ACHROMYCIN V Tetracycline blood levels are unsurpassed in the latest laboratory study. But actually how significant are any of these blood levels, clinically? It's really a matter of micromilligrams and fractional minutes! Let's not put Lederle in the position of giving this sort of evidence more emphasis than it deserves.

I think our job is to let doctors know that Lederle Research developed ACHROMYCIN V to give improved results under actual clinical conditions . . . to get a higher percentage of antibiotic to the tissues.

The fact that ACHROMYCIN V is the most widely prescribed broad-spectrum antibiotic ought to be pretty good evidence that physicians are consistently getting these results.

If your detail men will give doctors the complete story on antibiotics, I think ACHROMYCIN V prescriptions will continue to climb without any fancy blood level advertising.

J. D. Roberts

JDR:ep

Red Eye

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

A five year old girl was first seen by the ophthalmologist six weeks after onset of redness of her eyes. Apparently she had been originally diagnosed as having "pink eye" and was placed on a topical antibiotic. When this was ineffective, a series of different antibiotics were used in turn—all without arresting the course of the disease. Progressively, she developed photophobia, pain, blurred vision, more severe pain, and reduction of vision to light perception. Examination showed that the original disease had been acute iritis, which had produced extensive intraocular adhesions and blocked the flow of aqueous through the pupil causing secondary glaucoma. Surgery was required to treat the glaucoma, but did not restore vision. This outcome was particularly tragic since early use of mydriatrics and steroids probably would have prevented blindness. With rare exceptions antibiotics are *not* helpful in iritis.

Discussion

Redness of the eye is a warning signal common to many diseases. Most frequently encountered are the relatively insignificant allergies and superficial conjunctival infections. Danger exists that the frequency with which minor conjunctival inflammations are encountered may engender a feeling of security in dealing with red eyes. Such an attitude will lead to regrettable delay in making an accurate diagnosis and instituting definitive therapy for the more serious eye diseases.

How can the physician be sure he does not overlook presence of one of the serious and potentially blinding causes of red eye? Almost never will a really serious red eye not show the presence of not only one but usually several of the following criteria. Conversely, minor conjunctivitis does not present these findings.

Findings in a Red Eye Suggesting Major Disease

(1) **Vision.** Definite reduction in acuity occurring since the onset of redness should *always* be regarded with great suspicion.

(2) **Pain.** Severe discomfort strongly suggests corneal damage or serious intraocular or orbital involvement. Although painful corneal abrasions usually heal without trouble, they represent a potential portal of entry for infection and cannot be disregarded.

(3) **Opacities.** Fresh corneal infiltrations or debris within the normally transparent eye structures are always serious. Bright, obliquely directed, moving illumination as from a small flashlight is best for observation of anteriorly situated opacities. Opacities posteriorly situated in lens or vitreous are best appreciated as dark shadows against the ophthalmoscopic red reflex.

(4) **Pupil.** Irregularities in size and shape of the pupil result from intraocular inflammation or trauma. A smaller pupil on the side of a red eye is an excellent indicator of iritis, whereas an enlarged pupil suggests acute glaucoma (unless due to mydriatic therapy).

(5) **Distribution of Redness.** A red halo immediately encircling the cornea (limbal flush) almost invariably indicates serious eye disease. Redness diffusely distributed throughout the conjunctival area may occur with either benign or serious causes of red eye and has no diagnostic significance.

(6) **Pressure.** Noticeable alterations in pressure of the red eye, either hard or soft, as determined by finger tension estimation, indicates serious disease.

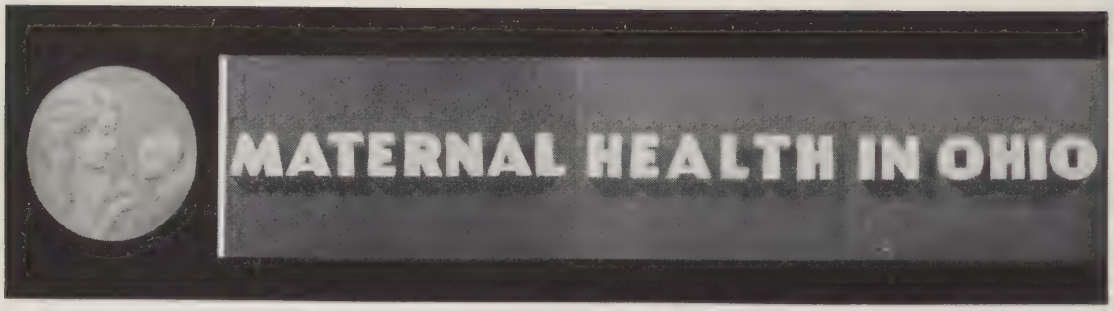
(7) **History.** Redness in an eye known previously to have suffered from serious disease such as uveitis or glaucoma must be regarded as a recurrence until proven otherwise. Presence of bacterial conjunctivitis in other members of the family suggests the diagnosis of this simple, benign infection.

(8) **Response to Therapy.** Should diagnosis of a minor cause of red eye have been made, failure to respond to adequate therapy within two or three days should cast doubt upon the accuracy of diagnosis.

If, by means of these eight signals of major disease, a red eye is determined to have a serious etiology, the cause should be diagnosed and receive specific treatment. Should the physician be unable to arrive at a diagnosis, urgent ophthalmologic consultation is in order.

The Author

● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**



WITH this issue of *The Journal,* the "Maternal Health in Ohio" column enters its third consecutive year of publication. The Committee on Maternal Health acknowledges with gratitude the wholehearted cooperation of Ohio physicians, county chairmen, and many others, without whose untiring efforts and assistance this study could not be maintained.

TOPIC THIS MONTH:

Maternal Deaths* Involving Pulmonary Embolism

Case No. 174

This 31 year old white, gravida IV, Para III, died 13 hours postpartum. She had had an appendectomy some years ago without sequelae. The patient had had no complications with her previous three pregnancies and her prenatal course with her final pregnancy was uneventful. Last menstrual period was October 10. At 37 weeks she was admitted to the hospital in active labor, at which time the physical examination was normal. Labor progressed satisfactorily (duration was given as 15 hours) and she delivered spontaneously with an ether anesthetic administered by a nurse. The placenta followed three minutes after delivery of the infant and disclosed absence of multiple cotyledons. The baby weighed 2381 grams; both mother and infant appeared perfectly well. *Thirteen hours* after delivery the mother suddenly began to gasp for air while engaged in a telephone conversation. The nurse was unable to obtain a pulse or heart beat; respirations ceased and she was pronounced dead 10 minutes later. Autopsy permission was obtained.

Pathological Diagnosis: Bilateral, massive pulmonary embolism; partial retained placenta. (The placental fragment was 3 cm. in thickness and was located in the left cornu of the uterus. Sections through the broad ligament failed to disclose evidence as to the origin of the embolic material.)

Comment

The Committee voted this a nonpreventable maternal death. The speed with which fatal sequelae occurred, obviously made intervention hopeless. The record reveals no exploration of the uterine cavity following discovery of the missing chunk of placenta; available information does not indicate that its removal would have changed the fetal course of the tragedy.

Case No. 187

This 34 year old white, Primigravida expired 16 days postpartum. The past medical history of this *obese* patient was not significant. She was first seen by her physician in the fourth month of gestation. Her height was five feet and she weighed 230 pounds. The original blood pressure was 130/80 and urine was negative for albuminuria. Last menstrual period was September 6; prenatal care was considered adequate. At 34 weeks gestation she was hospitalized because of hypertension (highest was 180/120), albuminuria and edema and was discharged after the toxemia was controlled. Therapy included low salt diet, Diamox®, Thiomerin® and bed rest. She was re-hospitalized at 40 plus weeks for treatment of her pre-eclampsia, at which time she weighed 272 pounds. X-ray pelvimetry did not reveal any disproportion.

On the fifth day of this hospitalization labor began spontaneously (3 weeks past term). She delivered a 10 pound, 11 ounce stillborn baby after a 24 hour labor. Delivery was accomplished with low forceps and episiotomy; anesthesia (type not reported) administered by a registered nurse. The third stage was reported normal. After delivery her blood pressure and urinary findings returned to normal and she was discharged on her sixth postpartum day. Details of laboratory studies were not recorded. Before discharge the blood pressure was 140/84.

At home the patient developed chills, fever and left chest pain on the tenth postpartum day and was readmitted to the medical service of the same hospital. Temperature was 100, moist rales were present in the left lower chest. There was tenderness in the left lower quadrant of her abdomen and there was 3 plus pedal edema bilaterally. Her symptoms improved on therapy consisting of rest, sedation and antibiotics. An x-ray on the 14th postpartum day showed consolidation in the left lower lobe interpreted as an *atypical pneumonia.* On her 16th postpartum day she became nauseated, apprehensive, cold, clammy and complained of severe abdominal pains. Her vital signs became unobtainable and she expired July 30. Autopsy permission was granted.

Pathological Diagnosis: Bilateral pulmonary infarcts, thrombosed pelvic veins and endometritis.

Comment

The Committee voted this case a nonpreventable maternal death. However, several items of interest were raised by members; it would have been

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

helpful to know reports of laboratory studies performed on the patient's blood. Second, when did attendants learn of fetal death? In view of the fact her estimated date for term was June 13, it would seem that induction of labor should have been considered prior to her final hospital admission July 25th.

Case No. 248

This 25 year old white gravida III, Para II died undelivered in the third month of gestation. There was no information on the past surgical or medical history. No data available on previous pregnancies. Last menstrual period was in November (?). The patient was known to have been involved in an automobile accident in a southern state in the third month of her pregnancy but information concerning the extent of injuries could not be obtained.

On February 23, (about one month after coming to Ohio) she noticed chest pain and abdominal distention and consulted a physician. She was given a cursory examination, at which time the pregnancy was confirmed, blood pressure was 100/80 and temperature was 99.8. The patient was given a placebo for "gas" and advised to contact the physician in 24 hours if no improvement was noted; this she did but the physician was not in at the time of the call. That night (Feb. 24) the patient suddenly collapsed and died in the living room of her home. She was not seen by the physician until after her death. Autopsy was performed.

Pathological Diagnosis: At autopsy there was present a dilated right heart; lungs showed massive bilateral pulmonary artery thrombosis and thrombi were noted in the broad ligament vessels. With the opening of the uterus it was noted that there was a 3 inch area of *placental separation* with some blood in the uterus. The fetus measured 20 cm. in overall length.

Comment

The Committee studied this case with a great deal of interest. Certain details omitted from the past history (i.e., a 4-inch scar over the left lower quadrant) might have helped to explain the background of the fatal processes. The insidious character of aseptic pelvic thrombosis is apparent from the report of this case. Obviously, the role of the trauma of the automobile accident as a contributing cause to the formation of the thrombi is a matter for speculation. The Committee voted this a nonpreventable maternal death.

Comment of Consultant

The following comment of a consultant, a specialist in thoracic surgery, was given at the request of the Committee.

The only common denominator in the three patients presented is that all three died of pulmonary embolus, found to be massive at autopsy. In **Case No. 174** the patient died 13 hours following a fairly normal though prolonged labor without evidence of previous pelvic infection or other contributory factors. This certainly is not the usual picture of pulmonary embolus. It would be extremely interesting to know whether the embolus was sectioned and possibly might have been placental tissue which entered the pelvic veins during this somewhat prolonged labor for a Para III. Since this embolization was totally unexpected and occurred while the patient apparently was ambulatory and occurred with such suddenness, any medical or surgical therapy even in the most ideal environment could not have been applied.

In the other two patients **(Case No. 187** and **Case No. 248)** there is definite evidence of previous pelvic infection. The record, however, is incomplete in that adequate data are not available indicating the duration and extent of such infection. Patients with symptoms and findings of pelvic sepsis should have a thorough investigation and specific antibiotic therapy and heparinization should be instituted. Statistics of carefully evaluated series are now available indicating that control of sepsis and the proper use of heparin will reduce the incidence of fatal pulmonary emboli.

Most pulmonary emboli occur in the fourth to the tenth day postoperative and post-delivery period of time and are not always massive in nature. Multiple smaller emboli may be the prodromal signs of disaster; however, the use of heparin in this period of time although not dissolving already present emboli will prevent the formation of arterial thrombi and will prevent the progression of pulmonary embolization which will lead to obstruction of the pulmonary arterial flow, hypertension, and eventual right heart failure.

A good discussion of the problems of pulmonary embolization was presented by the consultant on pages 1058 and 1059 of the August, 1958, issue of this journal.

Cautious Use of Steroids Advised

In the asthmatic child, corticotropin or corticoid hormones may be employed to arrest the symptomatic crisis. The physiologic activity of the hormones is used in a rational way, though less frequently, in dermatologic forms of allergy such as urticaria and angioneurotic edema. It has been established that corticotropin or ACTH tends to induce adrenal hyperplasia with glandular hyperfunction. Corticosteroids, however, may produce changes in the structure of the gland which may lead to atrophy of the cortex with subsequent hypofunction. A cautious use of steroids is advised. Repeated short courses are preferred and daily or continued routine administration of these preparations is thought to be ill-advised.

Overfamiliarity with these products may lead one to forget their tremendous potentiality and this is especially true in pediatric practice.—G. Estrada de la Riva, M. D., Havana: *South. M. J.*, 51:865, July, 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIRTY-SIX HOURS prior to admission to the University Hospital, Columbus, Ohio, this 67 year old white man developed generalized pain over the lower abdomen which was more intense in the right lower quadrant but did not radiate to the back, legs or umbilicus. The pain was described as a constant dull ache. A few hours after the pain started he became nauseated and vomited thick brown fluid without food particles. He vomited approximately eight times in 24 hours, about a cupful each time. He had had a meal 30 minutes before the pain started. He gave no history of previous abdominal pain. He had noted constipation two days prior to the onset of the pain.

The patient had been in good health until five years ago. He had had an asymptomatic umbilical hernia for years and had had hypertension for the past five years with blood pressure of about 170 over 110. He had had no blood transfusions or operations. For 30 years up until two years ago he drank 15 bottles of beer a day, since then five bottles a day. For the past five to six years he had noted vertigo and had been "hard of hearing."

Review of the cardiorespiratory system revealed some exertional dyspnea with asthma for 10 years and hypertension for five years; he had never had edema of his legs, or chest pain. Gastrointestinal history revealed poor appetite and constipation requiring cathartics for the last two months; he suffered a 10 pound weight loss during the last two to three weeks and had fatty food intolerance and mild intermittent jaundice for the past year. He had nocturia of three to four times.

Physical Examination

Temperature 99.4°F., respirations 24, pulse 80, blood pressure 90 over 40. He was a pale, obese white man who appeared chronically ill and in acute distress due to abdominal pain. His skin was dry and scaly, his lymph nodes were not enlarged or tender. His chest was increased in the posterior-anterior diameter, hyperresonant on percussion, with decreased breath sounds. Numerous coarse rhonchi with occasional fine rales could be heard over both bases. His heart was not remarkable.

The abdomen was distended and tympanitic; bowel sounds were absent. There was marked direct and rebound tenderness over the entire abdomen which was more marked in the right upper and lower quadrants. He had a 3 cm. umbilical hernia. A firm, irregular mass 5 to 6 cm. in diameter was palpable in the right upper quadrant. Due to tenderness it was not possible to decide whether this mass moved during respirations. The abdominal veins were not dilated.

Rectal examination revealed an enlarged prostate and tarry stool which was guaiac-positive. He showed no edema of his extremities, and his femoral pulses were equal. The neurological examination was not remarkable. On paracentesis no fluid was obtained from the right lower quadrant; from the left lower quadrant 6 cc. of turbid yellow fluid was obtained.

Presented by

- Daniel W. Elliott, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.

Laboratory Findings

Red blood count 4.32 million, hemoglobin 11.8 Gm.; white blood count 10,600 with 68 per cent nonsegmented neutrophils, 19 per cent segmented, 9 per cent lymphocytes, 4 per cent monocytes. Urinalysis: specific gravity 1.026; *p*H 4.5; protein 10 mg.; some coarse granular and rare fine granular casts; 2 to 3 white and red blood cells per high power field, bacteria 3 plus. His serum amylase was 962 units; his prothrombin time 52.6 per cent; the blood urea nitrogen 33 mg. and the blood sugar 115 mg.

His serum sodium was 126 mEq., potassium 4.1 mEq. and chlorides 93 mEq. His total serum proteins were 5.5 Gm. with 3.1 Gm. of albumin and 2.4 of globulin. His icterus index was 3; the thymol turbidity and the cephalin flocculation were negative. The inorganic serum phosphorus was 2.9 mg., his alkaline phosphatase 4.2 units. The bromsulphalein test showed 24 per cent retention. Electrocardiogram showed a nodal rhythm with A-V dissociation or fibrillation.

Roentgenographic Findings

The chest film showed enlargement of the heart, an elongated and tortuous aorta, congested lung

fields (the right greater than the left), and a small right pleural effusion. Anteroposterior and lateral films of the abdomen showed small amounts of gas outlining the colon and duodenum, and a long fluid level along the right colon, suggestive of free peritoneal fluid.

Hospital Course

On the second hospital day his blood pressure dropped to 80, the pulse was 88 and temperature rose to 102°F. Three paracenteses were attempted but no fluid was obtained. The next day he was more alert, his abdomen was softer but tender; peristalsis was still absent. He was noted to have expiratory wheezes and cough. The serum amylase dropped to 229 units; his blood urea nitrogen was 31 mg. His white blood count rose to 15,600. On the third hospital day his abdomen was tender but soft and peristalsis was beginning to appear. His temperature was 104 F., and his blood pressure 164 over 80. He was placed on Chloromycetin® and tetracycline.

On the fourth hospital day his temperature was still elevated. Paracentesis was attempted twice and again no fluid was obtained. On x-ray the degree of ileus seemed increased since the previous film. His serum amylase was 89 units. The following day many rales were present in both bases posteriorly. Bowel sounds were present; he passed a dark liquid strongly positive for blood on guaiac test. He developed thrombophlebitis of the right leg extending to the groin. On the fifth hospital day tracheotomy was performed. On the sixth day he seemed slightly improved and took some fluids by mouth. The thrombophlebitis was responding and there was a decrease of his edema. His temperature was 104°F. He received a whole blood transfusion.

On the seventh hospital day the chest seemed somewhat cleared, the abdomen less tender with good bowel sounds and no distention. Fluids were limited to 1000 cc. Temperature was 103-104°F. Suddenly he vomited thick greenish fluid. He was suctioned through the tracheotomy wound without return. His respirations and his heart beat stopped and he was pronounced dead at 10:50 a. m. of his seventh hospital day.

Clinical Discussion

DR. ELLIOTT: This elderly man was apparently brought to the hospital 36 hours after sudden onset of pain, and we would think of this as sudden because the man had eaten only 30 minutes before, so he must not have felt even vague symptoms of warning. The pain was diffuse across the abdomen, which is suggestive of a diffuse process irritating the peritoneum. He vomited almost immediately and his vomiting was of a type which may be found in intestinal obstruction, ileus, or any severe abdominal pain. Vomiting of brown fluid suggests that there may have been blood or feces in the vomitus. The fact that constipation had been present for two days before his sickness suggests the possibility of some obstruction underlying the abdominal process, but not necessarily so.

Looking for a background for his acute episode, we find several statements in the story to make it a little confusing. His asymptomatic umbilical hernia may well have been responsible for his acute episode. However, hernias almost invariably show some local symptoms if significant incarceration occurs. The past history of hypertension makes us think of arteriosclerosis with mesenteric thrombosis and the past history of alcoholism is also worthy of comment. Fifteen bottles of beer a day is a lot of beer, particularly when it is drunk habitually, and its alcohol content is about equivalent to two thirds of a fifth of whisky.

Vertigo

The fact that he had cut down on his beer lately suggests that he was not feeling as well as usual and that he had begun to have some type of abdominal symptoms as early as two years ago. The vertigo seems not related in any way that I know to the abdominal disease but is more suggestive of a chronic process like otosclerosis. The absence of chest pain suggests that his pain originated definitely in his abdomen and speaks against any myocardial disease which might be accompanied by mesenteric embolism. The story of a 10-pound weight loss suggests that there was some type of chronic disease in his recent past. The fatty food intolerance of no specified duration also points to some intra-abdominal disease, either two years ago when he cut down on his beer or a month or two ago when his weight began to decline. His recent constipation might be due either to an obstructive lesion such as diverticulitis or carcinoma, or it might be due to decreased food intake.

The mentioning of an intermittent jaundice seems extremely important in the evaluation of the patient's chronic disease background. It is important to know whether he really had jaundice. We gather that this jaundice was painless and was not accompanied by itching. The patient did not have jaundice when in the hospital because his laboratory findings were all negative, but we must consider all circumstances which will produce painless intermittent jaundice. Certainly any hemolytic process could do it, but then we would expect some degree of anemia, which he did not have. We might suspect liver cirrhosis on the basis of his alcoholism and also suspect gallbladder disease,

since we know that jaundice due to common duct stones can frequently be painless and may last only 24 to 48 hours. I believe that his jaundice was probably due to cirrhosis of his liver or some obstructive lesion.

When the patient looked for medical aid 36 hours after onset of his illness he already was in a severe state of shock. We know that he had had hypertension in the past and for this reason his blood pressure obtained in the emergency room indicated severe shock. Any acute abdominal emergency that produces shock in the course of 36 hours is a severe one. The fact that his pulse rate was not much increased may indicate some degree of myocardial limitation. We know that a good many older people when they lapse into shock cannot greatly increase their pulse rate because of chronic myocardial insufficiency.

Dehydration

He also was dehydrated, which would not be surprising with fluid pouring into his abdomen, his vomiting of fluid and his loss of electrolytes. His chest findings suggest emphysema with either bilateral basal pneumonia or pulmonary atelectasis due to elevated diaphragm. In any patient with 36 hours of acute abdominal pain, I would be inclined to explain the rales in both bases as compression atelectasis due to elevated diaphragm.

His generalized direct and rebound abdominal tenderness certainly suggests severe diffuse peritoneal irritation. The tenderness and the rigidity of his abdomen apparently prevented an accurate evaluation of the mass palpable in the right upper quadrant. Since it was irregular, I assume that it was not liver which the observer was feeling. The presence of guaiac-positive stools in his rectum would lead us to believe that he had a lesion within the gastrointestinal tract except for the fact that gastrointestinal bleeding occurs often in many shock-producing diseases.

I certainly agree that his was the type of abdomen in which paracentesis should be employed. The fact that fluid was obtained at all indicated an abnormal process occurring in the abdomen. Despite his dehydration his hemoglobin was not much elevated, and his white blood cell count indicated that he was acutely ill, while his urine analysis suggested a pretty normal renal function.

The test for serum amylase showed values clearly elevated beyond the range of any casual interference with normal amylase. So the question arises: What elevates amylase? The most important condition is of course pancreatitis. It elevates serum amylase within an hour or two after onset and at the end of four hours the level should reach its peak and start to drop. Rupture of the small bowels, perforation of a stomach ulcer and diseases of salivary glands, like mumps, will also elevate amylase but usually not that much. The reduced prothrombin suggests some degree of liver impairment. Although prothrombin will be less during starvation, it should not be reduced after only 36 hours of illness.

His blood urea nitrogen excludes primary kidney disease, and the blood sugar certainly rules out diabetes. His 24 per cent retention of bromsulphalein does not necessarily mean cirrhosis of the liver when it is obtained while the patient is in shock. The other battery of liver tests does not appear remarkable and certainly does not allow us to suspect any jaundice or obstruction of the biliary tree.

Summary

In summary then, all we know about this man is that he had a process going on which produced a lot of peritoneal irritation and paralytic ileus. X-ray examination confirmed these findings. He also was in shock. One most certainly would be reluctant to subject this man to surgery. Therefore we must rule out conditions for which surgery is mandatory. We do not have sufficient evidence to point to a dead or perforated viscus, which would require immediate surgical intervention. Therefore a tube was put in the stomach, his intestines were decompressed, and appropriate fluids were administered to get him out of shock.

He improved transitorily but lapsed again into shock with very low sodium levels. That suggests to me that he was given too much water and not enough saline in the course of his first management, and after he was treated with appropriate electrolytes he responded again and his abdomen seemed improved. His serum electrolytes became normal but he developed pitting edema and signs of bronchopneumonia.

As for his gastrointestinal tract bleeding, evidenced by the guaiac-positive stools, we know that 16 to 20 per cent of patients with pancreatitis show such bleeding for reasons that I do not definitely understand. We also know that 10 per cent of our patients with pancreatitis have acute cholecystitis. So we would not be surprised if the mass in his right upper quadrant would be an enlarged gallbladder, but we would operate only when we suspected it was about to rupture or had already ruptured. The fact that this mass was first palpable and later disappeared would lead us to wonder if the gallbladder was actually distended, acutely inflamed and later perforated, and one certainly would watch his abdomen closely for signs of bile peritonitis and tap him again when previous paracenteses were negative.

I think I accept the diagnosis of pancreatitis.

Since his abdomen improved, I feel certain that he did not have a condition for which we would need to operate. The principal reason to suspect pancreatitis was the fact that this man's serum amylase ran such a typical course. It became high within 36 hours after onset of his trouble and fell over the next 48 hours. This is about average time for amylase to drop, although the pancreas may well proceed to suppuration and pseudocyst formation. I therefore agree that the patient had pancreatitis.

The physical findings in his right upper quadrant suggest that he may have had chronic cholecystitis with gallstones. We know that two thirds of our patients with acute pancreatitis as their chief symptom will have gallstones, another 10 per cent will be alcoholics. In the remaining patients we cannot explain why pancreatitis should have occurred. I suppose that this man died of bronchopneumonia and congestive failure, and that we will find a hemorrhagic pancreatitis and a cholecystitis and possibly, but not necessarily, lesions of his gastrointestinal tract accounting for his bleeding.

General Clinical Discussion

DR. VON HAAM: Almost every student made the diagnosis of pancreatitis, but two thirds also felt that a malignant tumor was present which might have been either a carcinoma of the colon, pancreas, the liver or the gallbladder. Dr. Elliott, do you think that the patient had an occult malignant tumor?

DR. ELLIOTT: I don't think we have enough evidence to suspect an occult tumor in this patient. I think that if we had nursed him over his acute attack of pancreatitis and got him feeling better, then a diligent search should have been undertaken to exclude cholecystitis, peptic ulcer or an occult tumor.

Clinical Diagnosis

1. Acute pancreatitis with fat necrosis and peritonitis.
2. Chronic cholecystitis.
3. Alcoholic cirrhosis of the liver.
4. Bilateral bronchopneumonia.
5. Chronic pulmonary emphysema.

Pathologic Diagnosis

1. Acute pancreatitis with abscess formation, fat necrosis and acute peritonitis.
2. Chronic pancreatitis.
3. Chronic cholecystitis and cholelithiasis.
4. Severe parenchymatous and fatty degeneration of the liver.
5. Chronic pulmonary emphysema.

Pathologic Discussion

DR. VON HAAM: The patient was normally developed and moderately obese. The upper portion of the peritoneal cavity was sealed off by dense fibrous adhesions involving the omentum, the mesentery, the stomach, liver and pancreas. The peritoneum of this region was studded with multiple yellow plaques and covered with yellow fibrinous exudate. The pleural cavities contained 1300 cc. of dark amber fluid. The heart was enlarged but otherwise normal. The lungs appeared heavy and showed chronic emphysema of the upper lobes and congestion with atelectasis of the lower lobes. Both lungs were edematous and the small bronchi contained thick yellow exudate.

The liver was light tan and smooth. The gallbladder was thickened and contained mucoid bile and 20 mixed gallstones. The pancreas appeared swollen and was studded throughout with numerous yellow necrotic plaques. An abscess filled with greenish yellow pus was found in the region of the head of the pancreas. No bleeding points were discovered in the gastrointestinal tract, which appeared normal. The kidneys were swollen and finely granular. The remaining gross findings were not remarkable.

Microscopic Examination

Sections through the heart showed a severe and significant interstitial edema. The lungs showed chronic emphysema and severe edema. Sections through the liver showed severe fatty changes with slight increase in the thickness of the periportal spaces and some inflammatory cells in these areas. Sections of the gallbladder showed a rather severe chronic inflammatory process. Section of the pancreas showed typical changes of chronic interstitial pancreatitis in addition to acute changes of pancreatic fat necrosis. There were no hemorrhages or vascular changes and the areas of fat necrosis were not severely inflamed. Section of the kidney showed severe tubular degeneration and moderate arteriolar nephrosclerosis. The brain showed many small subependymal hemorrhages in the third and fourth ventricles.

In summary, the patient had most of the conditions which Dr. Elliott predicted. He had acute pancreatitis superimposed upon chronic pancreatic disease. He had cholecystitis with gallstones and a liver damaged by alcoholism. The fatal lesions at autopsy were the severe myocardial edema and his cerebral hemorrhages, both of which were probably caused by action of the circulating pancreatic enzymes with capillary damage. Overhydration also may have played some part in the accumulation of his hydrothorax. While the diagnosis in this case did not seem difficult, the management apparently was.

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

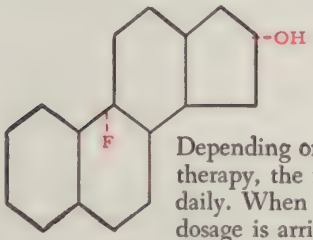
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...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

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Fall Postgraduate Courses . . .

District Organizations and Other Groups Arrange Interesting Programs; Excellent Postgraduate Material Within Easy Reach of Most Physicians

AGAIN this fall physicians of Ohio will have an opportunity to attend excellent postgraduate courses, several of them sponsored by district organizations. Many of the programs are annual events and are well known to physicians. Others have been designed to fulfill particular needs as refresher courses.

Scientific and clinical discussions are the core of these meetings, but no small part of the events are the banquets and other occasions for physicians to get together informally with their colleagues.

Additional information on these and other programs will be published in subsequent issues of *The Journal.* Following are the programs announced before this issue went to press:

September 19—Industrial Medical Association of Pittsburgh, Program on Industrial Medicine, Akron.

October 1 - 2—Ohio Academy of General Practice Annual Scientific Assembly, Toledo.

October 2—Eighth District Medical Meeting, Zanesville.

October 3—Montgomery County Medical Society Annual Founders' Day, Dayton.

October 17—Mississippi Valley Trudeau Society Annual Meeting, Dayton.

October 19—Third Annual Session on Rheumatic Diseases, Ohio State University, Columbus.

October 22—Sixth District Postgraduate Day, Akron.

November 1—Columbus Academy of Medicine, Clinic Day, Columbus.

Series of Postgraduate Courses—Bunts Educational Institute, Cleveland.

* * *

Industrial Medical Program To Be Conducted in Akron, Sept. 19

The Industrial Medical Association of Pittsburgh, a component society of The Industrial Medical Association, will present a program on Friday, September 19 at the Sheraton Hotel, in Akron.

9:00 A. M.—Registration—*Promptor Finis Fui.*

9:30—Greetings by Dr. Arthur Dobkin, president of the Summit County Medical Society. Remarks by Dr. Don A. Kelly, Cleveland, president of the Industrial Medical Association of Pittsburgh.

9:45—**The Use of the Artificial Kidney in Poison Cases,** Dr. Walter A. Keitzer, Akron.

10:15—**Lung Surgery as Related to Occupational Conditions,** Dr. William H. Falor, Akron.

10:45—Recess.

11:00—**Reconstructive Surgery in Industry,** Dr. E. J. Kraker, Akron.

11:30—**Rehabilitation of Industrial Workers,** Dr. K. C. Keeler, Akron.

12:00 M—Luncheon and showing of the film, "Medicine in the Tropics."

1:30 P. M.—**Panel,** Moderator, Dr. Paul A. Davis, Akron.

1. **Health Hazards in the Rubber Industry, Yesterday and Today,** Dr. Warren L. Hogue, Jr., Akron.
2. **Toxicology of Materials Used in the Rubber Industry,** Dr. Rex H. Wilson, Akron.
3. **Relationship of Industrial and Private Practice,** Dr. L. C. Hatch, Akron.

3:40—Business Meeting.

4:00—Cocktail Party.

* * *

Ohio Academy of General Practice To Meet in Toledo, Oct. 1 -2

The Ohio Academy of General Practice has announced its Eighth Annual Scientific Assembly to be held in Toledo, Wednesday and Thursday, October 1 and 2. Scientific programs and the exhibit will be in the Civic Auditorium and the banquet will be in the Commodore Perry Hotel.

The OAGP House of Delegates will convene on Tuesday, September 30, at 9:30 a. m. in the Crystal Room, Commodore Perry Hotel.

The program is acceptable for 13 hours Category I Credit for American Academy of General Practice members.

Wednesday, October 1

(All time is Eastern Standard)

8:00 Registration and Visit Exhibits

8:45 Opening Annual Scientific Assembly

9:00 **Therapeutically Induced Weight Gains in Hypertensives** — Dr. Harold S. Feldman, Livingston, N. J.

9:45 **Pre-Menstrual Tension — Psychogenic Dysmenorrhea**—Dr. Eduard Eichner, Cleveland

10:30 Visit Exhibits

11:15 **Diseases Caused by Viruses**—Dr. C. N. Christensen, Indianapolis, Indiana

12:00 Lunch and Visit Exhibits

1:30 **Office Management of Diabetes**—Dr. Geo. J. Hamwi, Columbus

(Continued on Next Page)

(Ohio Academy of GP — Continued)

2:15 **Endocrines in the Handling of Pregnancy**—Dr. Robert B. Greenblatt, Augusta, Georgia
3:00 Visit Exhibits
3:45 **The Emerging Awareness of Radiation Hazards**—Dr. William G. Myers, Columbus
4:30 Visit Exhibits
6:30 Social Hour and Banquet (Ball Room, Commodore Perry Hotel — Entertainment and Dancing.)

Thursday, October 2

8:00 Registration and Visit Exhibits
9:00 **Current Concepts in the Treatment of Congestive Heart Failure**—Dr. John Messina, Cleveland
9:45 **Surgical Emergencies in the Newborn**—Dr. Alan D. Shafer, Dayton
10:30 Visit Exhibits
11:15 **Trends in Pediatric, Adult and Geriatric Nutrition**—Dr. Julius Pomeranze, New York City
12:00 Lunch and Visit Exhibits
1:30 **Space Medicine**—Dr. Fred A. Hitchcock, (Ph. D.), Columbus
2:15 **Keeping the Arthritic Patient Going**—Dr. Edwin W. Passarelli, Chicago
3:00 Visit Exhibits
3:45 **Preparation for Marriage and Parenthood**—Dr. Milton Abramson, St. Paul, Minn.
4:30 Visit Exhibits
5:30 Adjournment

* * *

Eighth Councilor District Program In Zanesville, October 2

The Eighth District Medical Meeting will be held at the Zanesville Country Club, Thursday, October 2.

Morning golf will be available for those who wish to play.

From 2:00 to 4:00 in the afternoon a symposium on neurological diseases will be held with the following speakers from the University of Buffalo:

Dr. W. B. Hamby, professor of neurosurgery;

Dr. Bertram Bean, assistant professor of radiology; and

Dr. Bernard Smith, professor of neurology.

The ladies will be entertained with an afternoon tea. Registrants and the ladies may attend evening dinner featuring an entertaining speaker.

All physicians in the Eighth District will receive registration forms. Other physicians are invited to attend and may register by writing to Earl R. Haynes, M. D., Secretary, Eighth District, 838 Market Street, Zanesville, Ohio.

Montgomery County Society Founders' Day Program Scheduled Oct. 3

The Montgomery County Medical Society's annual Founders' Day meeting is scheduled at the Biltmore Hotel in Dayton, Friday, October 3. This event will mark the 109th anniversary of the organization.

All physicians of the Second Councilor District are being invited to attend this program.

The program will be in the form of a symposium on cancer chemotherapy.

The afternoon program will feature a workshop on chemotherapy. The evening program will consist of a panel discussion on the subject of the clinical application of chemotherapy. As is customary a social hour and dinner will be main attractions of the day's events.

The panel of some of the nation's leading authorities on cancer chemotherapy will include the following:

Dr. Kenneth M. Endicott, director of the National Institute of Health Cancer Division; and

Dr. Byron E. Hall, Stanford University Medical School, and director of the Western Cooperative Chemotherapy Study.

* * *

Mississippi Valley Trudeau Society Scheduled in Dayton, Oct. 17

The Annual meeting of the Mississippi Valley Conference on Tuberculosis and the Mississippi Valley Trudeau Society are to be held at the Biltmore Hotel, Dayton, October 16-18. The Trudeau Society meetings will be on Friday, October 17.

The program of the Trudeau Society has been announced as follows:

Morning Session

Presiding: Dr. William M. Spear, Vice-President, MVTS, Oakdale, Iowa.

9:30 **Chemotherapy of Tuberculosis, An USPHS Cooperative Study,** (Speaker to be announced.)
9:45 **The Present Significance of the Biological Inactivation of Isoniazid in the Chemotherapy of Tuberculosis,** Dr. J. Park Biehl, Christ Hospital Institute of Medical Research, Cincinnati.
10:05 **The Detection of Curable Lung Cancer,** Dr. Katherine R. Boucot, professor of preventive medicine, Woman's Medical College of Pennsylvania, Philadelphia.
10:45 **Eosinophilic Infiltrations in Lung,** Dr. Matthew B. Divertie, Mayo Clinic, Rochester, Minn.
11:05 Panel Discussion: **Atypical (Anonymous) Mycobacteria,** Moderator, Dr.

(Continued on Next Page)

(Trudeau Society — Continued)

Dieter Koch-Weser, Western Reserve University. Participants, Dr. Wendell H. Hall, chief of laboratory services, Veterans Administration Hospital, Minneapolis, Minn; Dr. Emanuel Wolinsky, Western Reserve University, Cleveland; and Dr. Lawrence E. Wood, Kansas City, Missouri.

Luncheon

Afternoon Session

Presiding: Dr. Harold G. Curtis, President, MVTS.

2:00 **An Analysis of Various Surgical Procedures for Primary Pulmonary Neoplasms,** Herbert C. Maier, director of surgery, Lenox Hill Hospital and associate clinical professor of surgery, Columbia University, New York.

2:45 **Interstitial Pulmonary Fibrosis,** Dr. Howard S. Van Ordstrand, and Dr. W. Robert Biddlestone, Department of Pulmonary Diseases, Cleveland Clinic.

3:05 **Needle Biopsy of the Parietal Pleura,** Dr. George S. Schools, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor.

3:25 Panel Discussion: **Inoperable Pulmonary Neoplasm.** Moderator, Dr. Virgil A. Plessinger, Cincinnati. Participants, Dr. Charles M. Barrett, professor of radiology-radiotherapy, University of Cincinnati; Dr. Maier and a third speaker to be announced.

4:30 **Bronchoscopy in the Diagnosis of Intrathoracic Disease,** Dr. Paul H. Holinger, Chicago.

5:00 Business Meeting.

* * *

Sixth District Postgraduate Day In Akron, October 22

An annual event that has become a leading scientific program in its area is the Sixth Councilor District Postgraduate Day, scheduled this year at the Sheraton-Mayflower Hotel, Akron, on Wednesday, October 22. This event drew well over 500 physicians last year, a large number of counties outside of the Sixth District.

A letter of instructions is scheduled to go to physicians within the District early in September informing them of the program and giving directions for advance registration.

Physicians who register in advance will have a choice of having luncheon with any one of the speakers where a free discussion in the form of questions and answers will be held. The general luncheon will be held at the Sheraton-Mayflower with the Obstetrics-Gynecology section luncheon at the Akron City Club.

The program is an all day event with registration beginning at 8:00 a. m. Section meetings will run concurrently so that each physician will have a choice of the program he wishes to attend.

The banquet will be a feature of the program. An outstanding speaker will discuss the general theme of medical matters allied with community responsibility.

This year 24 commercial exhibits have reserved space at the meeting place, emphasizing an increasing interest on the part of exhibitors.

The program had not been completed at the time this issue went to press, but speakers in two sections were confirmed.

Obstetrics and Gynecology

Speakers for the Section on Obstetrics and Gynecology will include:

Dr. Allen F. Guttmacher, chairman, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Dr. M. Edward Davis, chairman, Department of Obstetrics and Gynecology, University of Chicago and the Chicago Lying-In Hospital.

Dr. Frederic Zuspan, assistant professor of obstetrics and gynecology, Western Reserve University, Cleveland.

Dr. Clyde L. Randall, chairman, Department of Obstetrics and Gynecology, University of Buffalo.

Dr. John G. Masterson, assistant professor of obstetrics and gynecology, State University of New York College of Medicine, New York City.

Surgery

Speakers for the Section on Surgery will include the following:

Dr. Fred Coller, chairman of the Department of Surgery and professor of surgery, University of Michigan, Ann Arbor.

Dr. Deryl Hart, professor of surgery, Duke University, Durham, N. C.

Dr. Richard B. Cattell, director of surgery at the Lahey Clinic, Boston, Mass.

An all day program for doctors' wives has been arranged by the host auxiliary.

* * *

Columbus Academy Announces "Clinic Day" Nov. 1

The Columbus Academy of Medicine has announced plans for the second annual "Clinic Day" program to be held Saturday, November 1 at the new Franklin County Veterans Memorial Building,

(Continued on Next Page)

(Columbus Academy—Continued)

300 W. Broad Street in Columbus. Interested physicians of other counties are invited to attend.

The program announced by Dr. Arthur G. James, general chairman, includes nine out-of-state speakers. Final details will be announced in other issues of *The Journal,* and plans for pre-registration will be given.

Registration will begin at 8:30 a.m. with the first program feature at 9:30. The following speakers with the topics on which they will speak have been announced:

Morning Program

Dr. Paul Hodges, professor of radiology, University of Chicago, "Radiation Hazards in medicine."

Dr. Ray W. Gifford, consultant, Section on Medicine, Mayo Clinic, Rochester, Minn., "Fat, Diet and Atherosclerosis."

Dr. Rachmiel Levine, chairman, Department of Medicine and director of metabolic and endocrine research, Michael Reese Hospital, Chicago, "Newer Agents in Diabetes."

Dr. Robert J. Samp, Department of Surgery, Tumor Clinic, Wisconsin University School of Medicine, "Prevention of Cancer, Forty Possible Means."

Afternoon Program

Dr. Joseph E. Murray, Boston, Mass., "Experiences with Kidney Transplants."

Panel Discussion on Care of the Advanced Cancer Patient; Moderator, Dr. Charles A. Doan, dean of the Ohio State University College of Medicine.

Panel Collaborators: Dr. George T. Pack, attending surgeon, Memorial Hospital, New York City; Dr. Chester Southam, associate, Sloan-Kettering, New York City; Dr. Bronson S. Ray, professor of neurosurgery, Cornell University, New York City; Dr. James W. Carpender, professor of radiology, University of Chicago.

* * *

Day Course on Rheumatic Diseases At OSU on Sunday, Oct. 19

Third Annual Session on Rheumatic Diseases will be held on the Ohio State University campus on Sunday, October 19, from 9:30 a. m. to 3:30 p. m. Registration fee will be $5.00 which includes the price of the luncheon. The program will be presented in the Auditorium, Ohio Union.

The conference is sponsored by the National Institute of Arthritis and Metabolic Diseases of the National Institute of Health and the Franklin County Chapter of the Arthritis and Rheumatism Foundation.

Guest lecturer will be Dr. Joseph Bunim, director, National Institute of Arthritis and Metabolic Diseases, Bethesda, Md.

In addition, there will be panel discussions and presentations by other guests and by members of the staff of the Division of Rheumatic Diseases, Department of Medicine, Ohio State University College of Medicine.

Subjects to be covered by the speakers and panelists will include the following: "Scope and Distribution of Rheumatic Diseases," "Osteoarthritis," "Gout," and "Rheumatoid Arthritis and the Other Collagen Diseases."

Several exhibits will be presented including displays on the following: "Serologic Diagnosis of Rheumatic Diseases," "Personality Factors in Rheumatoid Arthritis" and "Aids for the Disabled."

Physicians attending the conference will be eligible for postgraduate credit from the American Academy of General Practice. The course is listed as an approved postgraduate course by the AMA.

Those planning to attend should notify those in charge and request a luncheon reservation by writing to: Division of Rheumatic Diseases, Department of Medicine, Room 103-B, Kinsman Hall, Ohio State University, Columbus 10.

Officers of the Northwestern Ohio Medical Association have announced that the usual meeting of that organization will not be held this year. Plans are being formulated for a meeting in 1959.

Bunts Educational Institute of Cleveland Schedules Courses in 1958-1959

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, 2020 East 93rd Street, Cleveland 6, has announced a series of postgraduate courses for the academic year 1958-1959. Details may be obtained by writing Charles L. Leedham, M. D., director of education, at the foregoing address. Dates and topics are as follows:

November 20-21—**Advances in Medical Technology.**

December 4 through April 9, 1959 (Thursday evenings)—**Physics of Radiology.**

December 10-11—**Recent Advances in Surgery.**

January 14-15, 1959—**Neuropsychiatry.**

February 11-12, 1959—**General Practice** (sponsored by the Cleveland Chapter of the American Academy of General Practice.

March 11-12, 1959—**Medical Progress and Its Relationship to Dentistry** (Sponsored by the Cleveland Dental Society).

May 13-14, 1959—**Newer Developments in Gastroenterology.**

Akron Doctors Teach in Traffic School . . .

Unique Traffic Safety Program Has the Assistance of Summit County Medical Society; Similar Projects Can Be Started in Other Counties

FIFTEEN-HUNDRED accident-prone traffic violators called together by Akron Municipal Court into a silent and sometimes sullen audience are the targets for the Summit County Medical Society's new Traffic Safety Committee. "These folks," says Dr. Paul L. Weygandt, Committee Chairman, "are somewhat of a challenge."

Dr. Weygandt will lead four other orthopedic men on the committee in a detailed presentation of case histories and crash experiences to this group in 13, one and one-half hour sessions between this September and next August. The doctors join a "faculty" that includes men from Ohio State Highway Patrol, the coroner's office, the city law department and prosecutor's office, local auto insurance and trucking companies.

The school is operated by the Akron Junior Chamber of Commerce which, with Judge Thomas M. Powers, organized it in 1953. It will meet every Monday night this year at an Akron University Building with doctors taking every fourth session.

According to committee member Dr. William L. Davis, "It's that kind of tangible project that takes safety programs out of people's speeches and puts them on the level of action."

School Curriculum

Here's what will take place at the school:

1. As noted above, the physicians will cover traffic injuries with slides of local casualties, case histories, a 16 mm film from Ford Motor Company entitled "On Impact," literature on driving attitudes and safety devices.
2. The insurance men will thoroughly treat with the "What and Why of Ohio's Financial Responsibility Law" and the results of non-compliance.
3. The law officers will offer reviews of the laws that brought the students to the school. "This," says Dr. James W. Parks, another doctor-instructor, "usually results in a change in attitude by a resentful offender."
4. The trucking company people will present defensive driving techniques and deal with driving attitudes. They also will use films and be aided by high school driver-training instructors.

Look for the Best

Seconding Dr. Davis' remarks on the tangible nature of the school, Dr. J. G. Roberts, on the society's traffic team, pointed out that doctors can best become part of important programs already organized in their communities. He advises: "Look around you for the best. Then join up and work. Steer clear of the lip-service-only projects." This was the technique the Summit County Medical Society has used to get something done about traffic safety after its Council called for action last January.

"You don't want to go off halfcocked but as the state Council has said too, the medical community does want to make a move on this front. Check your local library reference division, the Ford Company, Cornell University, the American College of Surgeons and your own files for facts. Do it carefully. Then present the positive solutions you can conceive. It works." This is the statement of Dr. B. K. Rothmann, committeeman in charge of research. He pointed out in conclusion that the 13 sessions to be handled by the five doctors only mean two or three evenings for each member and that such a program need not be confined to large county societies.

Akron Jay-cees plan to print and distribute in the near future as a public relations project a booklet on the school which will include a section on doctor participation. This will be available from the Summit County Medical Society for all interested doctors, Dr. Weygandt says.

Editor's Note:

The medical profession through its County Medical Societies has been asked by The Council of the Ohio State Medical Association to take an active part in the Ohio program on traffic safety. This story tells how one County Medical Society—the Summit County Medical Society—has gone about it to do the job. A program like the one starting in Akron can be initiated in most of the other counties of the state. All County Medical Societies please note!

Clevelander Takes New Post

Samuel Whitman, executive director of the Cleveland Mental Health Association for 11 years, has left that post to become executive director of the Cleveland Hearing and Speech Center affiliated with Western Reserve University.

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Deadline for Enrolling in Group Life Insurance Plan of Ohio State Medical Association Approaching; Better Send in Your Application at Once

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Ohio's Crippled Children's Services . . .

State Agency Modifies Some of the Policies and Summarizes Existing Rules in Regard to Eligibility for Care Paid For from Public Funds

BECAUSE of questions raised recently concerning the policies of the Division of Social Administration with respect to the care of crippled children, the Division has summarized, with some modification, the eligibility factors which are now in effect. The changes have the approval of the Advisory Council of the Division and are based upon the limited budget under which the Crippled Children's Service operates and the need to give increasing costly rehabilitative care to more children.

1. Financial Need

The child's family must be unable to provide care taking into account the resources of the family and the extent of the medical requirements. When a case is re-evaluated, financial eligibility is determined in exactly the same way as in a new case. If the anticipated cost of care in the future is such that the family should be able to meet the expense, the child will be discharged from state care. State nurses will continue to give consultation to local health agencies even though the cost of care is not being paid by the state.

2. Prognosis

Cases which offer a poor prognosis will not be accepted for care. If there is a poor prognosis at the time the annual medical re-evaluation is submitted, children will be discharged from care. Children will not be accepted if the social information, psychological report, or other information shows that the child has poor chances of making an adjustment.

No case will be accepted for custodial care only or continued under care for this purpose.

3. Cerebral Palsy

a. No case will be accepted in the future unless there is a psychological or a developmental report available to indicate the general intelligence level of the child. If no other report is available, this can be paid for by Crippled Children's Services.

b. In any severely involved case there must be an evaluation by a Cerebral Palsy Center team giving in detail the possibilities for rehabilitation. The team should include in addition to the physician, a physiotherapist, occupational therapist, and psychologist. If such an evaluation is not otherwise available, it can be paid for by Crippled Children's Service.

c. The Division is now planning to request an evaluation by a Cerebral Palsy Center team for each severely involved child who has been receiving care for three years or more. Each case will be considered on the basis of the evaluation of the team and of other information from the point of view of possible rehabilitation. If possibilities for improvement are slight, the child will be discharged from state care.

d. All new cases are being accepted on the basis of a trial period. The length of the trial period will vary from six months to one year depending upon the age of the child and the information available. An evaluation will be requested from a center at the end of the trial period. Cases in which the prognosis is regarded as fair to good may be accepted for a period of two years at the end of which time a complete evaluation will be made.

4. Time Limitation on Crippled Children's Service

With the exception of cleft palate cases, a five year period of care on the Crippled Children's Program is regarded as the maximum. Each child who has now been receiving care for five years or more will be evaluated by the medical director and cases will be evaluated in the future at least at the end of a five year period. Only those situations will be continued in which there is a clear and present need for service which cannot otherwise be provided.

5. Congenital Abnormalities

Infants will be accepted for surgical care on an emergency basis when there is a congenital abnormality other than an orthopedic anomaly or a need for plastic surgery, under the following conditions:

a. The surgery is performed by a trained pediatric surgeon who meets the requirements of board certification.

b. The prognosis must be reasonably good.

c. Approval of hospitalization will be for a maximum of 30 days only.

6. Burn Cases

Since the Crippled Children's Program is not a general medical program, burn cases will only be accepted after the acute period is past. The Di-

Please Notify Journal of New Address Promptly — Before Moving, If Possible

U.S. postage rates have increased. This means the OSMA will have to pay more to the Post Office Department for returning copies of *The Ohio State Medical Journal* which cannot be delivered because of wrong address.

Therefore, it is hoped that each member will keep the Columbus Office up to date on his mailing address.

If possible, send information on new address before changing locations to give *The Journal* mailing department time to make the change before another mailing.

Members having an office in a downtown building should supply the number of room to assure and expedite delivery.

vision will not pay for hospital care prior to the date on which skin grafting begins.

7. Convalescent Homes

Long periods of hospitalization or of care in convalescent homes are undesirable. No future approval for convalescent care will be given for a period of more than six months and no extension be granted unless it is clearly established that adequate care cannot be provided either in the child's own home or in a foster home.

8. Foster Home Care

a. The Division will pay the cost of boarding home care when the placement is required because the medical service is not available near his home.

b. The Division will pay the difference between the usual board rate of the county and the actual cost of board when the child is placed in a foster home because of the inability of the child's own mother to cooperate in rehabilitation plans. Payment by the Division will be approved for six months to one year with complete re-evaluation at the end of that period.

9. Medical Supplies

Medical supplies such as wheelchairs, special beds and hearing aids will be provided only when there are no other resources available. When requests are made for this kind of item, a local agency will be requested to explore resources such as the local society for crippled children, service groups, Red Cross, etc.

10. Applicable Mainly to Orthopedic Physicians

The business office will not honor billing for quarterly care except in the following two instances.

a. Billing for a surgical procedure should be only for the fee allowed by the department and includes three months after-care without additional charge.

b. Billing for cases requiring periodic cast changes can be on a quarterly care basis. Such cases may be authorized for one year or any part thereof if the physician asks for such authority from the Crippled Children's Service.

Cincinnati Institute Gets Grant for Antitumor Chemotherapy Study

Eight contracts totalling $859,442 with two pharmaceutical firms and five research organizations for producing possible anticancer agents and for laboratory studies on promising agents were announced by the Public Health Service. One contract was to an Ohio institution.

The Christ Hospital Institute of Medical Research, Cincinnati, will receive $197,019 to compare the antiumor effects of certain alkylating agents. These compounds, so named because of a particular chemical reaction they cause, are useful in restraining the growth of some types of cancer.

The contracts will be administered by the Cancer Chemotherapy National Service Center at the National Cancer Institute, Bethesda, Md.

Public Health Service contracts for cancer chemotherapy work now total approximately $9,750,000.

New Pamphlet by Dr. Palyi

Dr. Melchior Palyi, well known economist and financial expert, has written another informative, 36-page pamphlet entitled "Nationalizations—Ten Years Later." One chapter is devoted to socialized medicine. His searching and enlightening analysis should prove of great interest to the medical profession as well as to thoughtful people in business, public affairs, finance, and education.

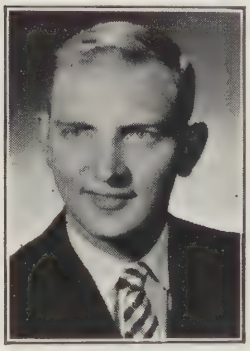
The booklet, costing 50 cents, may be obtained from the Heritage Foundation, Inc., 121 West Wacker Drive, Chicago 1, Ill.

Rural Health Activities . . .

Presentation of Rural Medical Scholarship; Lectures on Rural Practice To Medical Students, Preceptorships Among OSMA Committee Projects

THE Ohio State Medical Association Rural Medical Scholarship marked a decade in July with the awarding of the tenth such scholarship to Glenn D. Hisrich, Stone Creek, Ohio, Route 1.

The 21-year-old Tuscarawas County resident will use the $2,000 scholarship to help finance his medical education at the Ohio State University College of Medicine. He completed his pre-medical education at Ohio State in June.



Glenn Hisrich

The scholarship is administered by the Committee on Rural Health and this year's competition, along with other activities of the committee, appear to indicate a growing interest in rural medical activities.

Twenty Apply

Twenty students—a record number—applied for the 1958 award. The scholarship committee noted that the applicants nearly all had considerable background in rural living and rural youth activities. Members of the committee were Dr. H. R. Mayberry, Bryan, chairman; Drs. J. Martin Byers, Greenfield, a past-chairman of the Rural Health Committee; L. W. High, Millersburg, and Kenneth R. Taylor, Pickerington, all members of the Rural Health Committee.

Hisrich is the son of Mr. and Mrs. Vernon G. Hisrich. His father is a farmer and represents Tuscarawas County in the Ohio House of Representatives. His rural interests include extensive activities as a 4-H Club member and junior leader, Farm Bureau Youth Council, Juvenile and Subordinate Grange, Grange Youth Group, church young people activities and others.

Another program of the Committee on Rural Health which appears to be enjoying considerable success is that of providing the 4-H Club Personal Health Record for club members throughout the state.

Nearly 80,000 Used

Since this program was activated less than two years ago, nearly 80,000 of the records have been printed by OSMA and distributed to 4-H boys and girls through the State 4-H Office. In conjunction, the committee designed a simplified physical examination form which the state's 4-H Clubs have adopted.

The Committee's series of lectures on the advantages of rural practice was presented in a different format at Ohio State and the University of Cincinnati College of Medicine this year and resulted in increased attendance on the part of medical students and their wives. Instead of having five weekly lectures and a complimentary dinner the sixth week, a one-day program was presented.

The program consisted of a solid afternoon of informal talks and discussions, followed by the dinner the same evening. At Cincinnati, approxi-



This is the group of Ohio State senior medical students and their wives who attended the 1958 lecture program, held at the Ohio Union.

Students Hear Lessons on Practice



University of Cincinnati junior and senior medical students and their wives listen attentively to one of the speakers.



This panel delivered the 1958 "Special Talks to Medical Students" at the University of Cincinnati College of Medicine. Shown during a question and answer session are (left to right) **Dr. G. N. Spears,** Ironton, Rural Health Committee member who since then has been named chairman of the new Committee on Care of the Aged; **Dr. J. Martin Byers,** Greenfield, Rural Health Committee member; **Dr. Frank H. Mayfield,** Cincinnati, OSMA president-elect; **Dr. V. R. Frederick,** Urbana, Rural Health Committee member; **Dr. Richard R. Buchanan,** Wilmington, School Health Committee member, and **Dr. George A. Woodhouse,** Pleasant Hill, OSMA president. At the time of this meeting Dr. Woodhouse was president-elect and Dr. Mayfield was First District Councilor, and acted as chairman of the program.

mately 125 attended the afternoon session and 190, the evening dinner. At Ohio State, some 110 were present for the afternoon meeting and 164 at the dinner.

The one-day program is to be followed next year at Western Reserve, where attendance for the "once-a-week" series last March averaged only 14 students, while dinner attendance climbed to 100.

Active Participation

Presiding at the Cincinnati afternoon session and dinner was Dr. Frank H. Mayfield, president-elect and at that time First District Councilor. Dr. Edwin H. Artman, Tenth District Councilor, presided at Ohio State and Dr. George T. Petznick, Fifth District Councilor, presided at Western Reserve.

Speakers for the evening sessions at the three schools were Past-President Martin (then incumbent president), Mrs. V. R. Frederick of Urbana, Woman's Auxiliary president, and Dr. E. K. Yantes, Wilmington, at that time chairman of the sponsoring committee who since then has resigned from the committee.

Afternoon speakers at Cincinnati were President Woodhouse, Dr. V. R. Frederick, Urbana; Dr. G. N. Spears, Ironton; Dr. J. Martin Byers, Greenfield, and Dr. Richard R. Buchanan, Wilmington.

Afternoon speakers at Ohio State included Drs. Woodhouse and Byers, Dr. Robert E. Reiheld, Orrville, since then appointed chairman of the committee; Dr. John Miller, Orrville, and Dr. Charles H. McMullen, Loudonville.

Participating in the weekly talks at Western Reserve were Drs. Rieheld, Miller, Frederick and Dr. John H. Budd, Cleveland.

Preceptorships Recognized

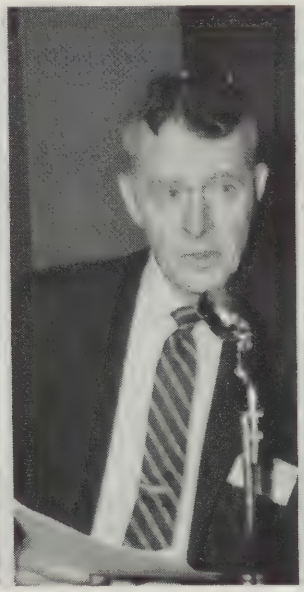
The Rural Health Committee's preceptorship program, started in 1957 at Cincinnati, resulted in





Dr. E. K. Yantes, Wilmington, Rural Health Committee chairman at the time, speaks on "The Physician and His Community" at the Western Reserve Dinner, and **Mrs. V. R. Frederick,** Urbana, then OSMA Woman's Auxiliary President, speaks on "The Physician's Wife" at the Cincinnati dinner. Dr. Martin, Dr. Yantes and Mrs. Frederick were the speakers for the dinners at all three medical schools.









At the Western Reserve University lectures and dinner, (left to right) **Dr. Robert S. Martin,** Zanesville, then OSMA president, is shown delivering the principal address at the student dinner; **Dr. John H. Budd,** Cleveland, speaks at the session on medical ethics; **Dr. John Miller,** Orrville, speaks at the session on selecting a place to practice and **Dr. George W. Petznick,** Shaker Heights, Fifth District Councilor, welcomes the students to the dinner program.

They Told What Practice Is



Shown addressing medical students during the session for Ohio State University College of Medicine seniors are (left to right) **Dr. Charles H. McMullen,** Loudonville, School Health Committee; **Dr. Edwin H. Artman,** Chillicothe, Tenth District Councilor and chairman for the session; **Dr. Robert E. Reiheld,** Orrville, recently named chairman of the Rural Health Committee, and **Dr. J. Martin Byers,** shown delivering his popular "It's in the Bag" talk.

an invitation to Dr. Reiheld to speak on "Preceptorship Program in Ohio" at the AMA National Conference on Rural Health in Jackson, Miss., last March. Also at the conference, Dr. Yantes and Dr. Robert E. Rakel, then a senior at Cincinnati and national president of the Student AMA, participated in a roundtable discussion of the advantages of rural practice, later printed in *The New Physician.*

Other activities of the committee include presenting subscriptions to *Today's Health* to each county boy and girl 4-H health competition winner in Ohio, sponsoring the state 4-H boy health winner at the National 4-H Club Congress, and assisting in the selection of the boy and girl state winner at the Ohio State Fair.

VA Reports Success on Its Program of Foster Homes for Mental Patients

Veterans Administration's nationwide foster home program to provide a normal home life for recovering mental patients has more than doubled during the past two years, the agency reported.

The total of 1,249 VA mental hospital patients living with their "adopted" families in private homes near the hospitals during 1957 was a 24 per cent increase over the number in 1956 and a 56 per cent increase over the number for 1955.

The hospitals placed 639 patients in the homes during 1957 and reported 219 of those in the program recovered sufficiently during the year to be discharged from hospital rolls.

NFIP Changes Title and Enters New Fields

The National Foundation for Infantile Paralysis has dropped the reference to a specific disease in its title. It will be known in the future as The National Foundation.

Projected plans center on the development of an organized voluntary force in the fields of medical research, patient aid, and professional education, flexible enough to meet new health problems as they arise, the organization states.

The first new goals will be research and eventually a patient aid program in arthritis and congenital malformations. Virus research will be continued and expanded as will the investigations currently being conducted into the disorders of the central nervous system.

No attempt will be made to duplicate the work of other voluntary agencies, Basil O'Connor, President of the organization said.

All five areas of the expanded program will be financed through the traditional March of Dimes conducted annually in January.

Health Commissioner Needed

The Journal has been requested to notify its readers that a health commissioner is needed for Lucas County. Physicians who are qualified and wish to apply for the position or those who wish additional information are invited to write the Lucas County Board of Health, 445 Huron Street, Toledo, Ohio.

Infections in Hospitals . . .

Joint Commission Issues Special Bulletin Enumerating Ways For Solving the Problem; Role of Physicians Emphasized As Important

FOLLOWING are excerpts from Bulletin No. 18 of the Joint Commission on Accreditation of Hospitals on a subject which has become of vital importance to physicians, hospital authorities and hospital patients. *The Journal* believes the question is so crucial that widespread publicity should be given to sound recommendations for solving it.

* * *

Quotes From Bulletin

The presence of infections in hospitals of various kinds will always be with us and we must accept it. To keep these infections to an absolute minimum is of paramount concern to all. This can be done only through continuous education and re-education of all hospital personnel to carry out known control methods with strict discipline at all times.

The Commissioners of the Joint Commission on Accreditations of Hospitals think that the matter is of such grave importance that they urge hospitals to study their own problem and set up systematic controls. The Commission cannot dictate what these controls should be. However, this Bulletin suggests an approach which might be used as a pattern. Each hospital should develop its own methods of study and control to meet its specific needs.

Committee Suggestions

The Commissioners recommend that every hospital have an 'Infection Committee' charged with the responsibility of investigation, control and prevention of infections within hospitals. Membership on this committee should include the medical staff, administration and nursing service personnel. Where possible, participation with community health organizations such as health departments, medical societies and hospital councils is recommended, because the problem is not necessarily confined to the hospital itself. The responsibility of the committee can appropriately include the following:

A. Establishment of definite controls. Control measures must have validity.

B. Establishment of techniques for discovering infections on patients who have left the hospital.

1. Trace source of infection for which a patient may be admitted.

2. Periodic sampling by letter, card, call or visit of discharged patients.

C. Make certain that bacteriologic services in or out of the hospital are available.

D. Establish a system of reporting all infections among patients and personnel and keep records as a basis for studying the source of infections.

Clean Techniques

Clean and aseptic techniques should be practiced on all services of every hospital at all times.

Educate and orient all personnel in the practice of aseptic techniques. An informed worker is a better and a safer worker. It is especially important that physicians not consider themselves the exception to the rule, but both teach and set a good example for all. There can be only one accepted standard of practice.

Control Use of Antibiotics

The medical profession has become increasingly aware of the problems created by the routine and indiscriminate use of antibiotics. Hospital surveys by the Commission reveal that the infection rate in most hospitals using antibiotics routinely is higher than in those not doing so. The common denominator in hospital infections appears to be the resistance of bacteria to antibiotics used on the individual case. From this, the conclusions drawn are that this increase in infections is due to the routine, indiscriminate use of preventive antibiotics in the absence of infection, and the indiscriminate use of antibiotics in the presence of infection without preceding cultures and sensitivity tests. In this latter type of case it is more than useless since without an adequate antibiotic, one may only inhibit the infectious agent and also at the same time stimulate the growth of other organisms which then become pathogenic.

The Human Factor

All the rules, regulations and controls mean nothing if hospital personnel do not constantly check themselves for human errors.

The recognition and elimination of infections in

patients and personnel are thought by many to be the most important single facet in the control of infections. No hospital employee with a carbuncle, boil, acne, paronychia, fungus infection, upper respiratory infection, diarrhea, common cold, or in fact any infection, should be allowed in contact with patients. The reverse is true of infected patients. They must be isolated. One of the commonest avenues overlooked is by the physician not notifying the admitting office of the presence of infection already in the patient, or the admitting office or floor nurse not recognizing its very obvious presence on admittance.

There is no single factor responsible for so-called hospital infections. There are many factors and causes and each should be investigated. The Joint Commission cannot supply and does not have literature on special techniques and treatments. For specific articles refer to medical and hospital library indices on the subject.

Physicians of State Institutions Form Professional Association

A new professional organization in Ohio is one closely associated with the task of treating some 28,000 patients in 25 mental institutions and installations in the state, plus the care of thousands in the correctional institutions.

The organization is the Association of Physicians of the Ohio Department of Mental Hygiene and Correction. Dr. Peter J. Brdar, Cleveland, chairman of the Publicity Committee, points out that about a year and a half ago physicians of the Department held an organization meeting in Columbus State Hospital. The Association was formed and now has over a hundred members with Dr. Alvin P. M. Hall, Cleveland Regional Treatment Center, as president.

Subsequent meetings have been held at Columbus State School, Cleveland Psychiatric Institute and Hospital, Scioto View Hospital at the Girls' Industrial School and Orient State Institute. The Association has the support of the Ohio Department of Mental Hygiene and Correction and Dr. Robert A. Haines, Department director.

The ultimate aim of the organization as outlined in the Association's constitution is to contribute toward better patient care, encourage free discussions of mutual problems, foster closer cooperation between local medical societies and the Association, safeguard the professional and economic integrity of the members, promote legislative action to train and retain qualified personnel and to enlighten and direct public opinion in regard to the care and treatment of the mentally ill.

Congressman McGregor Says Nix On Socialized Medicine Schemes

Physicians in the counties of the 17th Congressional District of Ohio (Richland, Ashland, Holmes, Coshocton, Knox, Licking and Delaware) will be interested in the remarks made on the floor of the House of Representatives on July 16 by their Congressman J. Harry McGregor, Coshocton, who is a candidate for re-election. Said Mr. McGregor, as reported by the *Congressional Record*:

"Mr. Speaker, the hearings just completed by the Ways and Means Committee on all titles of the Social Security Act have once again focused attention on the many problems of our wage earners and retired citizens. Of all of our problems, however, none deserves more careful attention than that of adequate medical care for our people, and no one is more eager than I am to see that such medical care is available.

"However, I am at the same time deeply alarmed by some of the proposals now being offered in the Congress, which, I am afraid, could easily lead to a complete socialization of medicine throughout the entire country, with a resulting deterioration in standards of medical care.

"If some of this legislation is enacted, we all will become, in effect, wards of a gigantic bureaucracy which is already far too big for its own good. I am extremely fearful that under this legislation we will lose our freedom of choice in selecting doctors and dentists, and I will do everything within my power to prevent such an outcome.

"Furthermore, I am just as afraid that should some of these programs be accepted, our doctors and dentists will find that their income depends on which political candidates they support, and not on their medical skill. For under these programs, not all doctors (and hospitals) would be allowed to participate, and even those who were allowed to take part in the program would have to depend on some bureaucratic government agency for their fees.

"In my opinion, Mr. Speaker, we cannot expect to find political solutions to serious health problems. We only create more serious difficulties by trying to do so. I am convinced that we can solve our medical problems, but not by imposing compulsory Government programs. Such programs, if enacted, will deprive all people, and especially the aged, of their independence, will force our doctors to rely on the whims of some bureaucratic agency for their livelihood, and will eventually result in inferior health facilities for us all. Mr. Speaker, I have always fought such programs, and I will continue the fight against socialized medicine."

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since July 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Columbiana County
Harold E. Ciccarelli, East Liverpool

Coshocton County
Lewis E. Smith, Jr., Coshocton

Cuyahoga County
Joseph Yared, Wickliffe

Franklin County
N. Stanley Lincoln, Falls Church, Virginia
Robert A. Stewart, Columbus

Hamilton County
Paul B. Klatte, Cincinnati

Portage County
Louis V. Castaldi, Ravenna
Kenneth F. Rupp, Kent

Noble County
Frederick M. Cox, Caldwell

Stark County
Marlin L. Abel, Canton
Henrich A. Brinks, Canton
Ernest E. Clark, Canton

Summit County
Robert C. Ackles, Akron

AMA Sponsoring Conference on Problems of the Aged

A nationwide conference to promote a more comprehensive program of medical society action in the field of aging, sponsored by the American Medical Association's Committee on Aging, will be held at the Drake Hotel, Chicago, September 13-14, and will be attended by members of state medical society committees on aging.

Purpose of the two-day conference is to coordinate activities of the medical profession on the national and state levels.

Objectives of such a coordinated program would be:

To seek public acceptance of a proper perspective toward older citizens.

To promote health maintenance and restorative services.

To encourage the training of personnel and the development of facilities for the care of the aged.

To cooperate in developing community programs for senior citizens.

To expand medical and socio-economic research in reference to aging and the aged.

To improve methods of financing health care for the aged.

Among participants will be Dr. Louis M. Orr, Orlando, Fla., president-elect of AMA; Dr. Henry A. Holle, Austin, Texas, a member of the Committee on Aging, and commissioner of Texas State Department of Health; Dr. Leroy E. Burney, Washington, D. C., surgeon general, U. S. Department of Health, Education, and Welfare; Dr. Edwin L. Crosby, Chicago, executive director, American Hospital Association.

Ohio Ranked No. 1 in Mental Facilities Construction

Ohio's $28 million dollars put into construction of new mental hospital facilities in 1957 made the Buckeye State No. 1 in the nation in that construction field, according to Governor C. William O'Neill.

Another $28 million slated for contract awards during 1958 is expected to retain for the state its No. 1 ranking this year, according to Robert A. Haines, M. D., director, Ohio Department of Mental Hygiene and Correction.

In a recent report to members of the Legislature, the Governor said the 1958 program will see the start of mental health facilities equal to the 1957 rate. While a few other states, notably New York, have more funds allocated for such construction than does Ohio, New York's projects failed to reach the "bricks and mortar" stage that would equal Ohio.

Gov. O'Neill noted that Ohio achieved the No. 1 position for the first time in its history. Projects were started during 1957 at Longview State Hospital, Apple Creek, Lebanon, Columbus, Cambridge, Dayton, Gallipolis, Toledo, Cleveland, Tiffin, Marion, Lancaster, Delaware, and Macedonia.

Following approval of a $75 million bond issue in 1955, a five-year construction program was started in 1956 and is scheduled for completion in 1960 and ultimately is expected to involve more than 40 projects.

Osteopaths Delete Name of Still from Objectives

In a revision of its constitution the American Osteopathic Association has removed the name of Dr. Andrew Taylor Still, the founder of osteopathy, from its statement of objectives.

As amended the constitution states that the objectives of AOA "shall be to promote the public health, to encourage scientific research, and to maintain and improve high standards of medical education in osteopathic colleges."

Sponsors of the change stated that the revision was a "desirable modernization to reflect the changes in today's health care." Dr. Carl E. Morrison, AOA immediate past president, said the revision should not be regarded as a change in association policy.

The sentence which was removed stated that "the evolution of the osteopathic principles shall be an ever-growing tribute to Andrew Taylor Still, whose original researches made possible osteopathy as a science."—*Hospitals, J. A. H. A.*

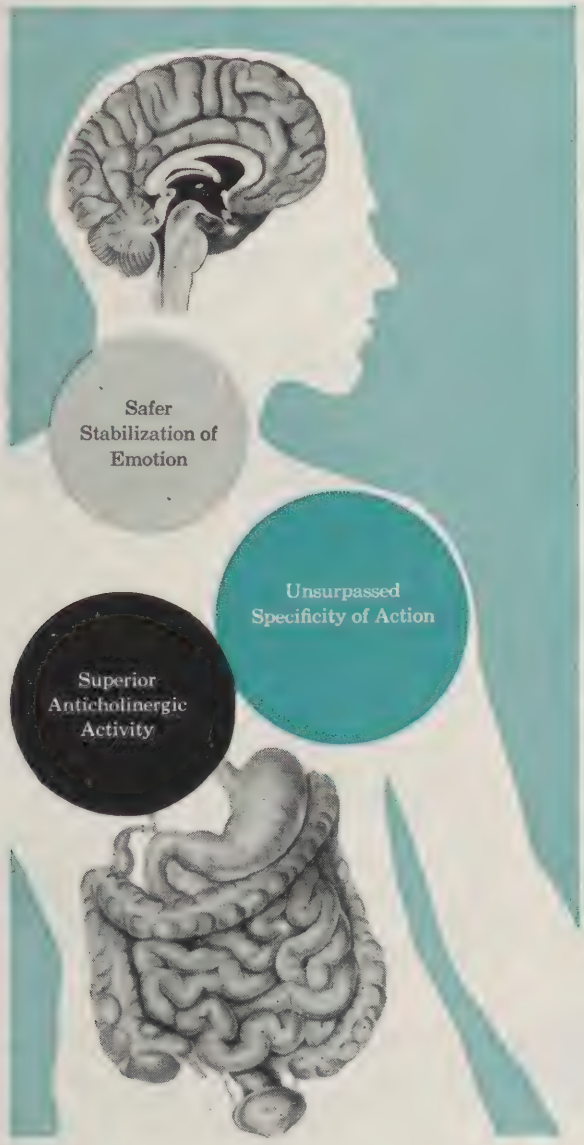
Controls Stress

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– for positive relief of cholinergic spasm.

– a new and safer agent for normalizing emotions.



PRO-BANTHINE WITH DARTAL offers you a new, specific and reliable control of visceral motor disorders, especially when these disorders are induced or aggravated by psychic tensions or anxiety.

Pro-Banthine has won wide clinical acceptance as the most effective drug for controlling gastrointestinal hypermotility and hypersecretion.

Dartal, a new phenothiazine congener, offers greater safety, flexibility and effectiveness in stabilizing emotional agitation.

The combination of each drug in fully effective doses in Pro-Banthine with Dartal gives a new means of approach to the medical management of functional gastrointestinal disorders mediated by the parasympathetic nervous system.

Specific Clinical Applications: Functional gastrointestinal disturbances, gastritis, pylorospasm, peptic ulcer, spastic colon (irritable bowel), biliary dyskinesia.

Dosage: One tablet three times a day.

Availability: Aqua-colored tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).

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Research in the Service of Medicine.

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Rest Home and Nursing Home Rules . . .

State Agency Adopts Revised Regulations for Licensing and Operation Of Facilities Providing Care for Aged and Physically Infirm Persons

REVISED regulations governing the licensing and operation of rest homes, convalescent homes and boarding homes for the aged and physically infirm have been put into effect by the Division of Social Administration, Department of Public Welfare.

One change in the regulations requires a minimum of 70 square feet per patient in future homes and a minimum of 60 square feet per patient in existing homes.

The new regulations were adopted after an 18-month study. They spell out in more detail, among other things, the extent of medical services these homes must provide.

Medical Consultant

Under Rule 21, "Provisions for Care of Patients," the medical services section provides with regard to nursing homes:

"a) Each nursing home shall have as a medical consultant a physician licensed in the State of Ohio to provide medical care for residents not having an attending physician or for care in case the attending physician cannot be reached in case of emergency and to assume responsibility for the general adequacy of the nursing care rendered in the home.

"b) It is recommended that all residents have a pre-admission chest x-ray. If a chest x-ray cannot be obtained, a series of sputum examinations should be done in lieu thereof.

"c) If new residents are not accompanied by a record of physical findings, diagnosis and signed doctor's orders for treatment, diet, activity, etc., the administrator shall secure this information within 48 hours after admission from the resident's attending physician, or if the patient has none, from the medical consultant for the home.

"d) No medication or treatment is to be given without doctor's orders. If orders are given by telephone, they shall be recorded by the licensed practical nurse or registered nurse on duty with the doctor's name, and the order shall be signed by the doctor on his next visit."

Rest Home Supervision

Under the regulations governing rest homes, the following rules cover medical supervision:

"a) Each rest home shall have a medical consultant licensed in the State of Ohio on call to provide medical care for residents not having an attending physician or for care in case the attending physician cannot be reached in case of an emergency.

"b) All residents shall have a physical examination by a licensed physician before being admitted or within a week after admission. It is recommended that this physical include a chest x-ray or sputum test.

"c) A physical examination shall be completed on each resident once each year. This examination may be completed by the resident's attending physician or, if none, by the medical consultant for the home.

"d) A resident may be responsible for taking own medicine provided the attending physician writes an order to this effect.

"Exception: The requirements of medical supervision shall not apply to non-profit homes established for and maintained by Christian Scientists."

Records System Required

The regulations provide that medical records in nursing homes "shall be prepared, maintained and filed in a manner approved by the Division. They shall be kept for a minimum of one year after discharge or death of the resident."

As for rest homes, the regulations state, "A record of each resident to include name, residence, age, sex, nearest relative and other necessary information shall be kept in a manner approved by the Division. Any medicine or treatment given to residents shall be recorded by the person administering the medicine or treatment."

Rule 17 defines a nursing home as "any place, residence or home used for the reception and care, for a consideration, of three or more persons who by reason of illness or physical impairments require skilled nursing services.

"A nursing home is licensed to provide personal services as required and other service requiring nursing skills which the ordinary untrained person cannot administer, such as administration of medicine * * *. A nursing home may admit residents not requiring nursing care."

Rest Home Defined

A rest home is defined as "any place, residence or home which provides care, for a consideration, for three or more persons who are dependent on the personal services of others by reason of age

and physical or mental impairments but who do not require skilled nursing services."

A complete copy of the laws, rules and regulations governing licensing and operation of such homes may be obtained by writing the Division of Social Administration, Department of Public Welfare, Ninth and Oak Streets, Columbus.

On January 1, 1959, a city ordinance becomes effective in Columbus that is somewhat parallel to the state regulations.

Booklet Gives Results of Hill-Burton Survey

Results of a two-year study of the Hill-Burton Hospital Survey and Construction Program is available in booklet form from the Committee on Medical and Related Facilities of the AMA Council on Medical Service.

In addition to reviewing the legislative background of the act and a voluminous amount of other data, reports on field surveys made in the following states are included: Arkansas, California, Connecticut, Georgia, Illinois, Iowa, Kentucky, Maryland, Michigan, Mississippi, Montana, New Jersey, Oregon, and Washington.

A limited number of copies will be available to individual physicians and medical societies.

General Fancher Named Director of Health Service at Ohio State

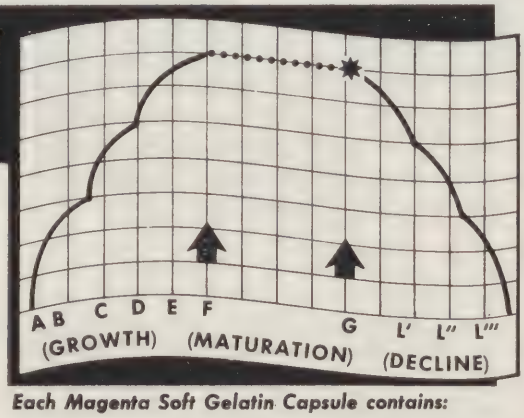
Ohio State University's Board of Trustees has named as director of the University Health Service Brig. Gen. Paul S. Fancher, who retired July 1 as commanding officer of Letterman Army Hospital, San Francisco, Calif. Effective September 1, he succeeds Dr. John Wilce who retired this summer after a distinguished career at OSU.

A native of Ohio, General Fancher is a 1925 graduate of Ohio Wesleyan University and received the doctor of medicine degree from Ohio State in 1930. His assignments before going to Letterman included that as chief of the Department of Medicine, Walter Reed Army Hospital. During World War II he commanded the 76th General Hospital in this country, England and Belgium. He is a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

John R. Wilson, D. D. S., has been named associate dean and professor, College of Dentistry, Ohio State University. He formerly was chairman of the Division of Periodontology in the College. Dr. Wilson succeeds Hamilton B. G. Robinson, D. D. S., who left Ohio State to accept appointment as dean of the School of Dentistry of the University of Kansas City.

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Properly balanced Androgen — Estrogen — nutritional therapy may prevent premature aging and damage of gonadal decline and nutritional inadequacy.

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Rx GERITAG in preventive geriatrics.

Each Magenta Soft Gelatin Capsule contains:

Methyltestosterone	2 mg.	Thiamine Hcl.	2 mg.
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Ohio's Nursing Future . . .

Survey Shows Need for Increased Number of Administrators, Teachers And Supervisors To Meet Projected Needs of the Profession by 1970

OHIO needs considerably more nursing teachers, administrators and supervisors on the baccalaureate and master's degree level to meet its future nursing requirements, according to a report of the Division of Nursing, Ohio Department of Health.

The report was written from a comprehensive survey to determine the state's nursing needs by 1970. A preliminary report of the study indicated that registered nurses in the state will have to be increased by 36,000 in the next 12 years to meet the need, as was reported in the July issue of the *OSM Journal* (p. 943.)

The report details the findings of a comprehensive survey conducted by questionnaire, as well as data from the study by Frieda I. Stewart, Associate Professor of Nursing, Ohio State University, on "The Increasing College Age Population of Women in Ohio; Implications for Nursing Education in Ohio."

Nurse Education

Approximately one-third of the state's general hospitals, having about 50 per cent of the total beds in Ohio, were surveyed. It was discovered that 708 of the teachers, administrators, and supervisors need graduate preparation on the master's level; and 1073 of the nurses need baccalaureate preparation. The report commented that "the remaining two-thirds of our general hospitals will need to prepare their present staffs at the same level."

Of the faculty nurses in 62 professional schools of nursing, there are approximately 115 directors and assistant directors; of these, 58 lack preparation on the master's level. And 633 instructors out of the 734 need to complete graduate preparation.

In view of information obtained, the report added, "the college and university controlled programs have better prepared faculty than the hospital or diploma programs."

In the 16 approved schools of practical nursing it was found there are approximately 18 directors and assistant directors who should have preparation on the graduate level. In addition, 71 of the 76 instructors and supervisors need graduate preparation.

Nursing, Maternity Homes

A selected sample of 125 nursing homes of the state's 800 licensed nursing homes was surveyed and only 37 returned the questionnaire. The findings of this survey were thus inconclusive. However, the report estimated that 550 nurses are needed in nursing homes, this figure being based on the need for a minimum of one registered nurse in each nursing home offering nursing care of the sick. "The qualifications of these nurses at this time," the report continued, "is that of a staff position. The nurses would require preparation on the diploma level."

In the 20 maternity homes surveyed, it was learned there were 30 nursing positions listed as either supervisory or administrative; only one nurse so classified has a baccalaureate. "It would seem," the report stated, "that, of these positions, six should have graduate preparation and 24 would require . . . a minimum of a baccalaureate."

The state's 22 mental hospitals have 36,000 beds and approximately 410 nurses employed in administrative and supervisory positions. (But there are 473 unfilled positions, the hospitals indicated.) Of the 138 administrative and supervisory personnel, about 8 per cent have completed the master's degree. Only 1.1 per cent of the 272 head nurses and assistant head nurses have the minimum preparation of the baccalaureate degree.

The Ohio census of industrial nurses as of January, 1957, indicated 1350 nurses were employed in industry. Every nurse working alone, or as a supervisor of multi-nurse service in industry, should have a baccalaureate degree as a minimum preparation, the report said. Thus 848 industrial nurses currently employed need this level of academic preparation.

Of the 296 public health nursing agencies in Ohio, there are approximately 131 nurses in a supervisory or administrative capacity; 107 of these still need preparation on a graduate level. And of the approximately 1122 nurses employed in staff positions, 893 still need baccalaureate preparation.

Nursing Needs

In the 62 schools of nursing in Ohio, enrollment reached 6300 in 1956. If the present rate of increase (one tenth of one per cent a year) continues, enrollments can be expected to reach 12,000 by 1965 and 17,000 by 1970.

The task of providing instructors for this group should have high priority in future plans, the re-



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port urged. Since 1951 only 104 nurses have completed a graduate program in Ohio universities.

Population increase alone requires that Ohio supply a considerable number of nurses to maintain the current ratio of 232 nurses per 100,000 population. To improve nursing services to Ohio's population, it is recommended the ratio be increased to 300-350 per 100,000.

1970 Projection

To achieve this ratio by 1970, Ohio will need 40,000 nurses. In order to have 40,000 nurses active in 1970, Ohio must provide 2770 nurses annually.

In four fields of nursing—hospital, public health, industrial health and health teaching—23,500 nurses must be added in the next 13 years to meet suggested standards. Of the number, approximately 12,500 need preparation at the baccalaureate level and 5,000 need graduate preparation.

A copy of the Ohio report may be obtained by writing the Division of Nursing, Ohio Department of Health, Ohio Departments Building, Columbus 15, Ohio.

Dr. Keller Heads State Chronic Diseases and TB Divisions

Martin D. Keller, M. D., M. P. H., has been named chief of the Divisions of Chronic Diseases and Tuberculosis in the Ohio State Department of Health. He also is to serve on the faculties of medicine and preventive medicine at Ohio State University.

Formerly with the Epidemic Intelligence Service of the United States Public Health Service, Dr. Keller first came to Ohio on loan as an epidemiologist in 1953. During 1954 he served as acting chief in the Division of Communicable Diseases in the State Department of Health.

During the last three years he has been doing graduate work at Columbia University and the Veterans Administration Hospital in New York, during which he completed requirements for specialty in internal medicine and also obtained his master's degree in public health.

Dr. Keller did his undergraduate work at Yeshiva University, earned a Ph. D. in bio-chemistry at New York University, and was awarded his medical degree by Cornell University Medical College.

The University of Pittsburgh has established a health law center within the Graduate School of Public Health. Its purpose is to pursue studies concerning the legal aspects of medicine, dentistry, nursing, public health, hospitals and medical care.

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 13. Vaginal Approach to Pelvic Surgery, one week, Oct. 6. General & Surgical Obstetrics, two weeks, Oct. 27.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3. American Board Review Course, one week, September 29 — (Oversubscribed — Available again in Spring, 1959).

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Two-week intensive course, Oct. 13. Ten-day practical course in Cystoscopy by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 1. Clinical Uses of Radioisotopes, two weeks, Sept. 29.

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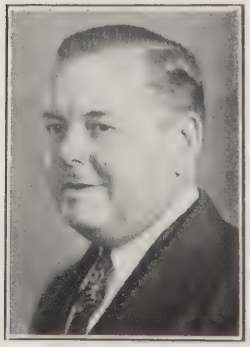


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In Memoriam . . .

Ralph L. Rutledge, Sr., M. D., recently of Alliance, Past-President of the Ohio State Medical Association, died on July 23 at the age of 65. Dr. Rutledge served as President of the OSMA for the term 1947-48. He had previously served on The Council as Councilor for the Sixth District beginning in 1939.



Dr. Rutledge

Dr. Rutledge received his medical degree from the University of Pittsburgh in 1916 and took postgraduate work at Harvard Medical School, the New York Orthopedic Hospital and the New York Postgraduate Medical School. During World War I he served with the Army Medical Corps in France in the grade of captain.

His practice in Alliance began in 1919 and continued until his retirement last November. He was a past-president of the Stark County Medical Society and served in numerous other capacities in his local organization. Professional organizations to which he belonged in addition included the American Medical Association, the American Fracture Association and the American Academy of General Practice. He was an elder in the Presbyterian Church, a past-president of the Rotary Club and was active in a number of Masonic bodies.

Survivors include his widow, a daughter and a son, Dr. Ralph L. Rutledge, Jr., of Alliance.

Emmett B. Shanley, M. D., New Philadelphia, former member of The Council of the Ohio State Medical Association, died on July 21 at the age of 83. He served as Councilor from the Seventh District from 1930 to 1934.

Dr. Shanley was a practicing physician over a period of 60 years, 57 years in Tuscarawas County. He had been honored with the 50-Year Award of the OSMA. An active participant in medical organization for many years, he was a past-president of the Tuscarawas County Medical Society and served the local organization in many other capacities. Other local contributions include service as registrar of vital statistics for over 50 years. He was a member of the American Medical Association and a member of the Masonic Lodge. Dr. Shanley was a graduate of the Starling Medical College, Columbus, class of 1898. A son survives.

Guy E. Noble, M. D., St. Marys, former member of The Council of the Ohio State Medical Association, died on August 4 at the age of 77. Member of a pioneer family of Auglaize County. Dr. Noble returned to St. Marys to practice immediately upon completion of his medical training in Columbus, where he graduated from the Starling Medical College in 1905. An early believer in organized medicine as a way of upholding the ideals of the profession and protecting the public, he has held every office in the Auglaize County Medical Society, being president in 1947-1948. He also was delegate to the OSMA for many years.



Dr. Noble

Dr. Noble served on The Council as Councilor for the Third District from 1940 to 1946. In his County Society he served for many years as chairman of the important Committee on Legislation, as well as serving on many other local committees. Another local responsibility was that as health officer for St. Marys. His practice included a long term as surgeon for the Nickel Plate and New York Central Railways.

Professional affiliations included membership in the American Medical Association and the American Academy of General Practice. Other memberships included those in the Rotary Club, the Methodist Church and several Masonic bodies. Surviving are his widow, two sisters and a brother, Dr. Walter A. Noble, of Lima.

Greer A. Allen, M. D., Springfield; Meharry Medical College, 1921; aged 64; died July 24; member of the Ohio State Medical Association and the American Medical Association through 1956. Dr. Allen practiced medicine for 32 years in Springfield before his retirement two years ago. He was a member of the Methodist Church. Surviving are his widow, two daughters, a son, three sisters and a brother.

Waldo Z. Baker, M. D., Youngstown; Ohio State University College of Homeopathic Medicine, Columbus, 1918; aged 67; died August 5; member of the Ohio State Medical Association. Dr. Baker practiced his profession for some 40 years in Youngstown. He was a Mason and a member of the Presbyterian Church. Surviving are his widow, a daughter and three sons, one of

whom is Dr. Norman Baker, now doing residency work at Mayo Clinic.

Richard P. Bell, Jr., M. D., Cleveland; Western Reserve University School of Medicine, 1945; aged 38; died July 26; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Oto-Laryngology, Association for Research in Ophthalmology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. A native of Lakewood, Dr. Bell practiced in Cleveland and Lakewood area and previously was on the faculty of Western Reserve University School of Medicine. He was captain in the Army Medical Corps during World War II. Affiliations included memberships in the Masonic Lodge, the Westwood Country Club and Nu Sigma Nu. Surviving are his widow, two sons and two daughters; his parents, Dr. and Mrs. Richard P. Bell, Sr.; a brother, Dr. David M. Bell, now with the Army; and a sister.

Theodore A. Campbell, M. D., Wapakoneta; Medical College of Ohio, Cincinnati, 1897; aged 83; died July 8; former member of the Ohio State Medical Association and the American Medical Association. A recipient of the OSMA 50-Year Award, Dr. Campbell practiced for more than 61 years in Auglaize County. A veteran of the Army Medical Corps of World War I, he was a member of the American Legion. Other affiliations included membership in the Woodmen of the World. Survivors include two daughters, a brother and a sister.

Louisa S. Cervone, M. D., Youngstown; University of Wooster, Medical Department, Cleveland, 1900; aged 80; died August 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Cervone retired in 1951 after 50 years of practice in Youngstown and was honored in that same year with the OSMA 50-Year Award. She was active in the Federated Women's Club; the Illalee Club and other groups. Surviving are her husband, Joseph B. Cervone, a daughter, a brother and three sisters.

Carl J. Dillon, M. D., Newark; Starling Medical College, Columbus, 1907; aged 75; died July 30; member of the Ohio State Medical Association and the American Medical Association; past-president of the Licking County Medical Society. A practitioner in Newark for most of his professional career, Dr. Dillon was awarded the OSMA 50-Year button. Active in many local affairs, he was



a member of the Presbyterian Church, the Elks Lodge and the Modern Woodmen. A brother and sister survive.

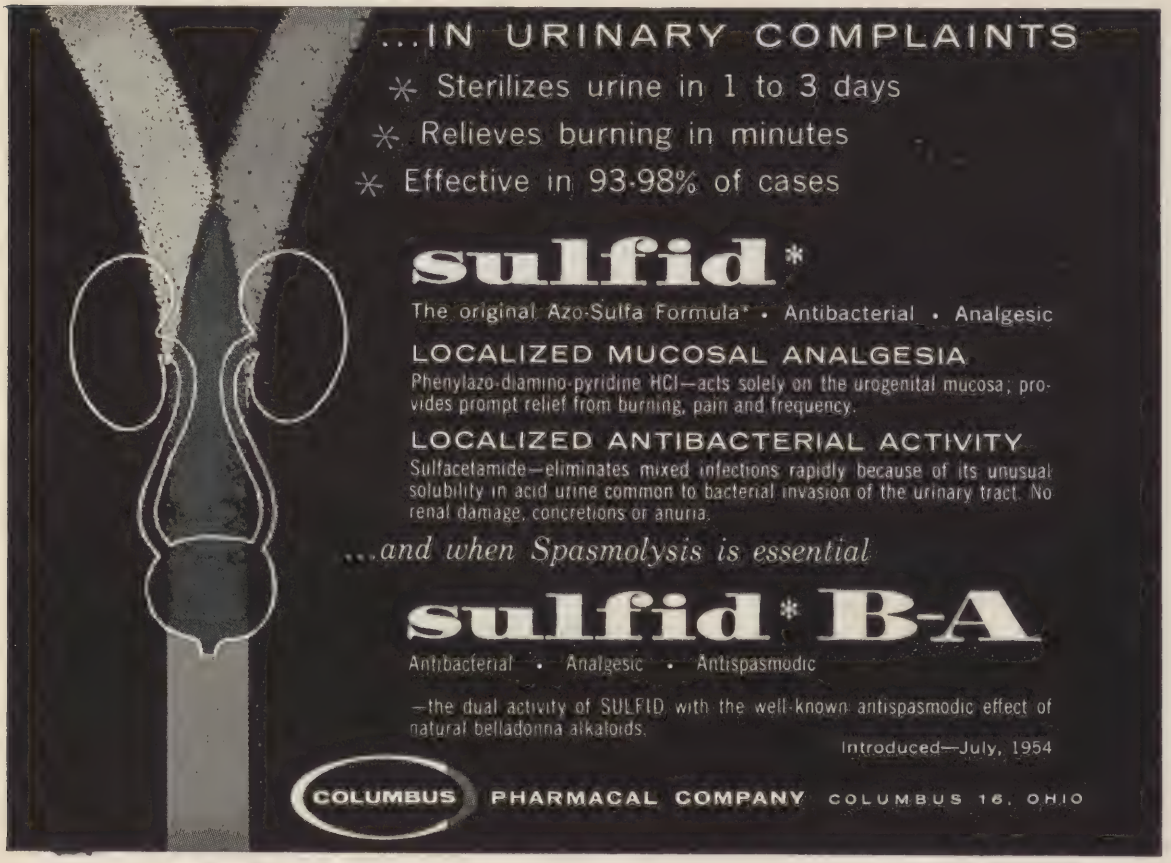
Fred L. Eyestone, M. D., Toledo; University of Maryland School of Medicine and College of Physicians and Surgeons, 1916; aged 65; died July 20; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Eyestone practiced for nearly 40 years in Toledo, having moved there shortly after World War I during which he served with the Army Medical Corps. He was a member of the Episcopal Church. Surviving are his widow, a brother and a sister.

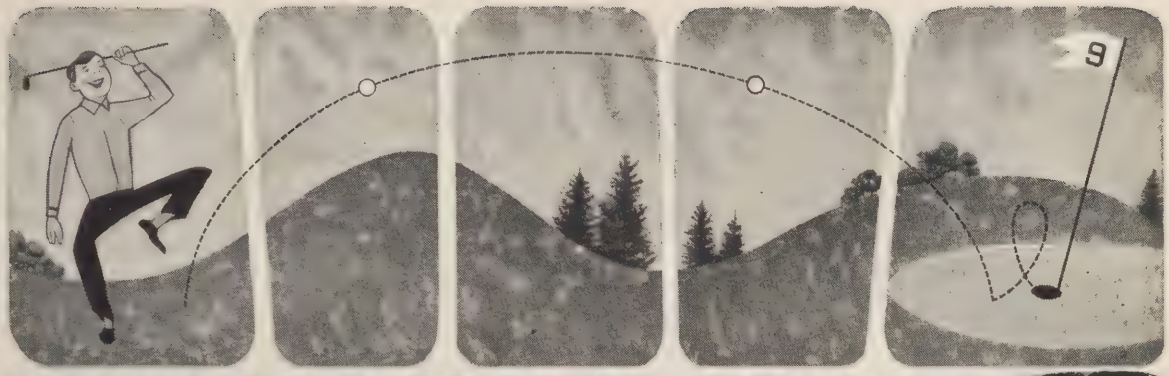
G. Bruno Fliedner, M. D., Cleveland; Western Reserve University School of Medicine, 1910; aged 71; died August 2; former member of the Ohio State Medical Association. A native of Cleveland where his father, the late Dr. Frederich Fliedner practiced before him, Dr. Bruno Fliedner served all of his professional career there, with time out for service in the Army Metdical Corps during World War I. He is survived by a daughter and three sisters.

Harry H. Haggart, M. D., Cincinnati; St. Louis College of Physicians & Surgeons, 1921; aged 66; died July 13; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology & Oto-Larygology; diplomate of the American Board of Otolaryngology; member of the American Society of Plastic and Reconstructive Surgery; member of the Board of the American Rhinologic Society, and a past-president of the Ear, Nose and Throat Society of Cincinnati. Dr. Haggart practiced for 30 years in Cincinnati, having moved there from Bluefield, W. Va., where he practiced for about three years. Surviving are his widow and two daughters.

Herman P. Hyder, M. D., Bentonville; University of Arkansas School of Medicine, 1917; aged 73; died July 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Hyder served a large part of his medical career with the federal government and was superintendent of the government hospital at Nashville, Tenn., before he moved to Adams County. He was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow, a brother and four stepchildren.

Reid P. Joyce, M. D., Xenia; University of Pennsylvania School of Medicine, 1932; aged 50;





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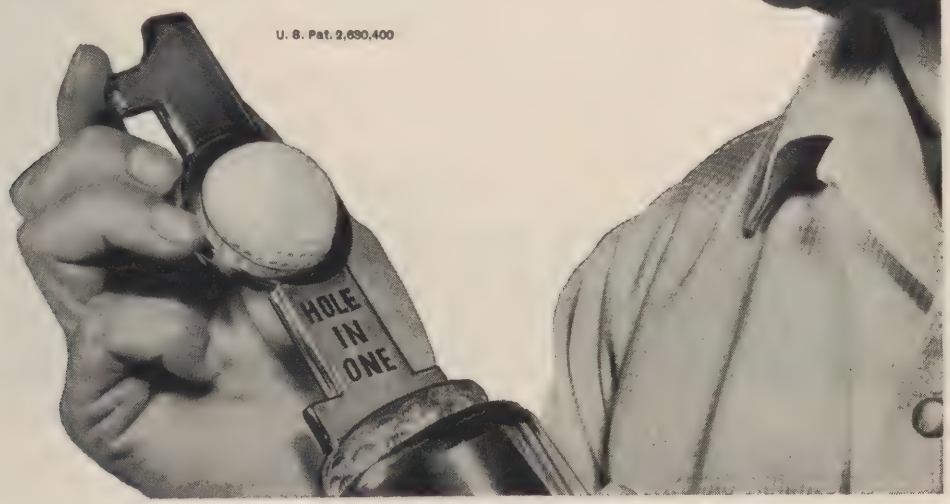
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died July 16; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Dr. Joyce moved his practice to Xenia in 1954. He had previously practiced in Sarasota, Florida, Dayton and Ashland. While in Dayton he was one of the founders and editor of the *Montgomery County Medical News*. In Xenia he was chief of the Xenia-Greene County Cancer Clinic. Affiliations included memberships in the Presbyterian Church and the Rotary Club. Surviving are his widow; two sons; his father, Dr. Charles W. Joyce, of Fletcher, Okla.; and three brothers, one of whom is Dr. Frank Joyce, of Denver, Colorado.

Vincent A. Killoran, M. D., Fort Lauderdale, Florida; University of Toronto Faculty of Medicine, 1927; aged 58; died July 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Nine years ago Dr. Killoran moved to Florida from Sandusky where he had been in practice about 15 years. He is survived by his widow, a son and a daughter.

Lowell W. King, M. D., Salem; Western Reserve University School of Medicine, 1918; aged 65; died June 29 in a traffic accident; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology & Oto-Laryngology. Dr. King was a practicing physician in Salem for 36 years. A veteran of World War I, he was a member of the American Legion. Other affiliations included memberships in the Masonic Lodge, the Elks Lodge and the Rotary Club. Surviving are his widow, five sons, including Dr. Lowell R. King, and a sister.

Fernand J. Leblicq, M. D., Sandusky; Cleveland-Pulte Medical College, 1913; aged 65; died July 17; former member of the Ohio State Medical Association. Dr. Leblicq practiced medicine in Sandusky for 43 years. He was a member of the Evangelical and Reformed Church, a past-com-

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mander of the local American Legion Post as a veteran of World War I, and past-president of the Lions Club. Surviving are his widow and a daughter.

Charles Walter Manss, M. D., Arlington, Va.; Miami Medical College, Cincinnati, 1902; aged 81; died June 28; former member of the Ohio State Medical Association. Dr. Manss practiced medicine in Cincinnati for 30 years before he retired in 1934. He moved to Virginia about a year ago. Surviving are a son with whom he made his residence, a sister and a brother.

James R. May, M. D., St. Clairsville; Western Reserve University School of Medicine, 1936; aged 48; died July 22; former member of the Ohio State Medical Association and the American Medical Association; member of the American Trudeau Society. Dr. May was a recent health commissioner of Belmont County and formerly practiced in Lakewood and Cleveland. He was veteran of World War II, having served in the Army Medical Corps with the rank of lieutenant colonel. Surviving are his widow, two sons, a daughter, his mother and a sister.

Charles R. Meek, M. D., Lorain; Ohio State University College of Medicine, 1913; aged 71; died August 2; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Meek was a practicing physician in the Lorain area for 45 years and former local health commissioner. Active in a number of local affairs, he was a member of several Masonic bodies, the Knights of Pythias, the Elks Lodge and the Methodist Church. Surviving are his widow, a son, a daughter, a brother and two sisters.

Claude W. Montgomery, M. D., Sycamore; Ohio Medical University, Columbus, 1900; aged 86; died July 7; member of the Ohio State Medical Association and the American Medical Association. Upon completion of his medical training Dr. Montgomery moved to Sycamore and practiced for a lifetime there. In 1950 he was honored with



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1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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the 50-Year Award of the Ohio State Medical Association. A sister survives.

Bushnell R. Reynolds, M. D., Bakersfield, California; Washington University School of Medicine, 1899; aged 82; died July 10. Dr. Reynolds practiced for many years in Greenwich, Ohio, before he retired about five years ago and moved to California. A son with whom he made his residence in California and a brother in Greenwich survive.

Robert A. Stack, M. D., Lorain; University of Cincinnati College of Medicine, 1920; aged 63; died August 4; member of the Ohio State Medical Association, the American Medical Association, the Industrial Medical Association; Fellow of the American College of Surgeons. Upon completion of residency training in Cincinnati and New York, Dr. Stack returned to his native Lorain to begin practice in 1923. He was a veteran of World War I, having served in the Army Air Corps. His professional work included membership on the American Cancer Society executive Board and the Lorain Board of Health. Other organizations to which he belonged included the Moose Lodge, the Elyria Country Club, the New York City Athletic Club, the Spring Valley Country Club, the Elyria and Lorain Yacht Clubs. He also was a member of the Catholic Church. Survivors include his widow, five sons, a daughter, two brothers and four sisters.

Frank R. Stansbury, M. D., Cincinnati; Pulte Medical College, Cincinnati, 1906; aged 79; died July 16. Dr. Stansbury practiced for many years in the Oakley section of Greater Cincinnati. He was a member of the Baptist Church. Surviving are his widow, a step-son, two brothers and two sisters.

Ohioans Certified by American Board Of Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology has announced certifications of the following Ohio physicians:

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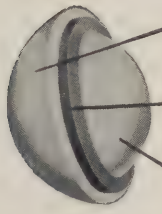
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Rules Listed for Healthful Foreign Travel

Physicians often are called upon to advise patients on health precautions to be taken before and while touring outside of the United States. Here are some common sense pointers on the subject compiled by Ray Vicker, a Chicago Writer, in the August issue of *Today's Health.*

Before leaving, a person must have a smallpox vaccination, since a vaccination no older than three years is necessary for re-entry into the United States. Moreover, many countries require a vaccination for entry.

A few Latin American countries also require a personal health certificate issued by a physician. Even if a certificate is not necessary, it might be advisable to have a physical examination prior to departure, Vicker said. The doctor can recommend any special precautions for health protection and can advise on the preparation of a first aid kit.

If a person is going to a country outside Europe, he should have yellow fever and cholera immunizations and perhaps a tetanus shot, he said.

Vicker noted that drinking water is safe in most of the big cities of Europe and many of the small. However, when in doubt, a person should drink bottled water. Ice cubes should be skipped unless they are known to be made from pure water. If water cannot be boiled it can be treated with a chemical in tablet form.

Stomach upsets, common to travelers, are often caused by contaminated food or water, eating indiscretions, or eating habits upset by time changes. Vicker suggested that a person take with him Kaomagna, Kaopectate and bismuth-paregoric preparations for such difficulties. (Obviously, the doctor may wish to advise the individual patient on what remedies to take.)

Unless milk is boiled, it should be avoided in many countries. The exceptions are Australia, New Zealand, Great Britain, Holland, Belgium, Switzerland, and the Scandinavian countries. In India, Malaya, and certain other countries, hot milk is served on cereal. This is a sign that the milk has been boiled, the author said.

Ice cream, butter, and fresh cheese are also taboo if the milk in a country is unsafe. And in the tropics, the taboo should be extended to include cold pastries, custards and meringues.

In preparing a first aid kit, a traveler should include sunburn lotion, aspirin, lotion for insect bites, and adhesive bandages, in addition to remedies for stomach upsets, seasickness, and malaria.

If a person wears glasses, he should take an extra pair or a prescription for his lens, Vicker added.

Central Ohio Blue Cross Now Covers N and M Hospitalization

Central Hospital Service Association (Blue Cross plan in Central Ohio) now offers hospital service covering mental and nervous disorders, alcoholism and drug addiction, the association announced.

The new coverage is available only to group subscribers and offers 30 days' hospital service a year. Time spent in a hospital under the plan, however, will be deducted from the total to which the policy holder is entitled under his regular hospitalization contract.

Rates for full service coverage on the new contract will be 50 cents a month for individuals or 95 cents a month for family contracts.

Mid-West Allergy Program

The Mid-West Forum on Allergy will hold its annual meeting on December 6 and 7, 1958 at the Sheraton-Cadillac Hotel, Detroit, Michigan. This meeting of the Forum is sponsored by the Michigan Allergy Society. For further information write to John M. Sheldon, M. D., General Chairman, in care of the University Hospital, Ann Arbor, Michigan.

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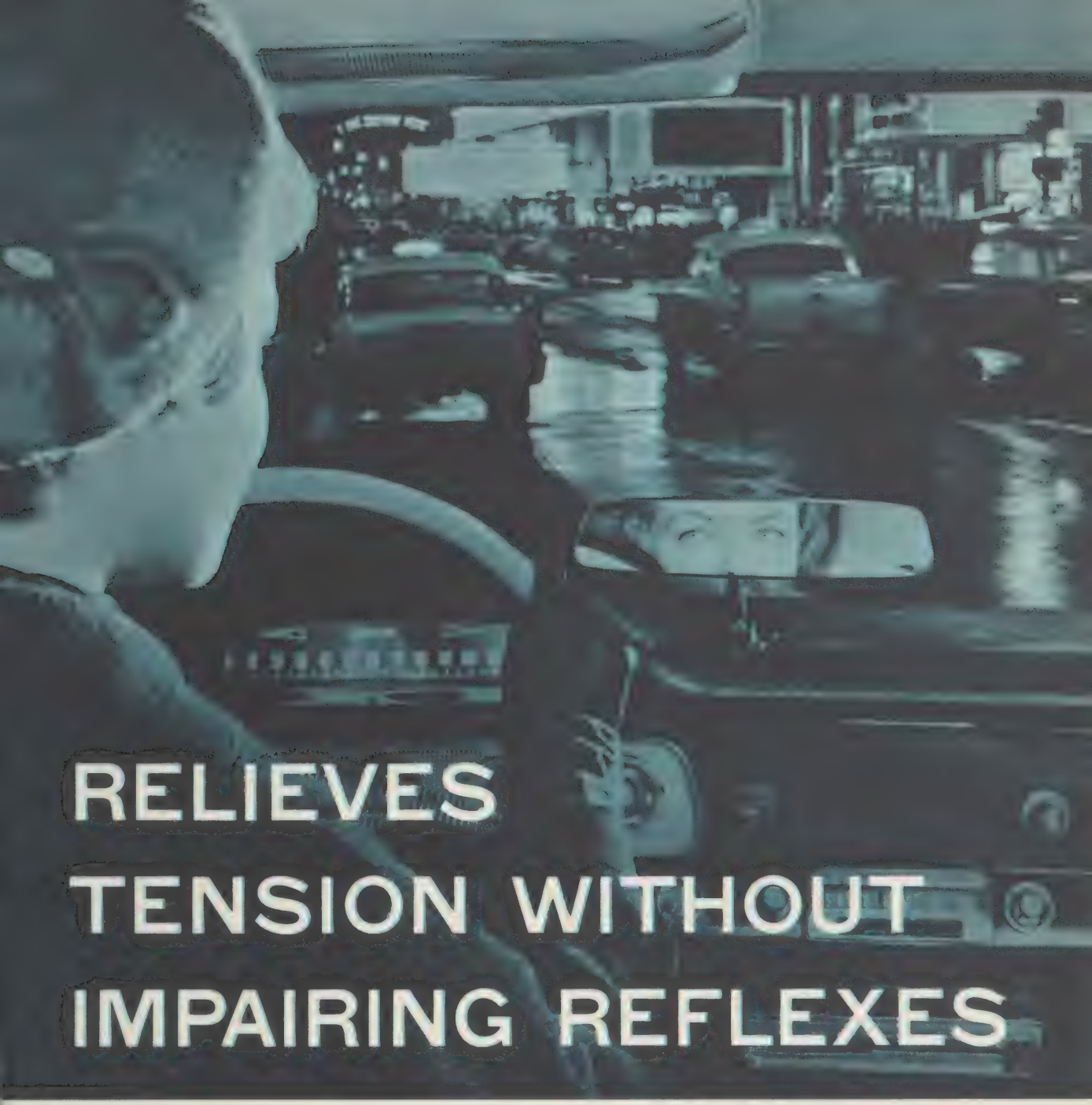
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*Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.

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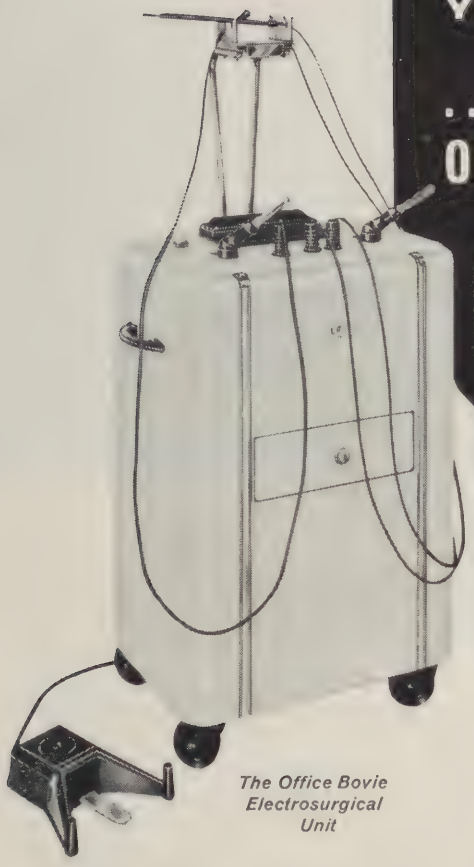
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New Officers of Ohio State Surgical Association Are Announced

The Ohio State Surgical Association recently completed a mail poll of its members and named as president-elect Dr. George N. Bates, Toledo. Dr. Stephen W. Ondash, Youngstown, was elected secretary.

Previously elected members to the board of directors are the following: Area 1, Dr. Robert G. Smith, Circleville; Area 2, Dr. Kent L. Brown, Cleveland; Area 3, Dr. E. F. Pfanner, Dayton; Area 4, Maurice F. Lieber, Canton; Area 5, Dr. William B. Faircloth, Zanesville; Area 6, Dr. Stephen A. Harris, Steubenville; Area 7, Dr. W. A. Blank, Toledo (re-elected); and Area 8, Dr. Vinton E. Siler, Cincinnati.

Cleveland has been selected as the convention city for 1959. Tentative dates are for the second week in June—exact time to be announced later. Dr. John H. Lazzari, immediate past-president, is 1959 general chairman.

At the OSSA annual meeting in Cincinnati Dr. Max M. Zinninger, professor of surgery at the University of Cincinnati, was made an honorary member. The award was made at the close of the second day's scientific sessions before some 125 surgeons from all parts of Ohio for his aid in setting up a "faculty" of leading surgeons for the 1958 program. Dr. Zinninger, though not a member of the group, volunteered to work with Dr. William Altemeier, chairman of the program committee. Dr. Altemeier also received recognition for an outstanding program, as did Dr. Clyde S. Roof, Cincinnati, the meeting's general chairman.

In presenting the honorary membership, the first since 1954, President Lazzari noted that only two other such memberships had been granted—one to Dr. Paul R. Hawley, Chicago, director of the American College of Surgeons, and the other to Dr. Harris E. Shumacher, professor of surgery at the University of Indiana.

Current president of the OSSA is Dr. Robert D. Mansfield, Cincinnati, who succeeded Dr. Lazzari.

Dr. Worden Leaving Ohio State To Take Post at UCLA Medical School

Dr. Ralph E. Worden has resigned as professor of physical medicine and director of the Rehabilitation Center, Ohio State University College of Medicine to become professor of physical medicine and chairman of the department of physical medicine and rehabilitation at the Medical School, University of California at Los Angeles. He will take over his new post about October 1.

Congress Asks for Study on Prepaid Medical Plans for the Aged

The House Ways and Means Committee of the 85th Congress, which omitted the Forand hospitalization proposal from its social security bill, in its report calls on the Secretary of HEW for a study of the various possibilities for financing medical care of the aged. The Secretary was instructed to have the study completed by February 1, 1959.

The committee told HEW to place special emphasis on the possibility of increasing social security taxes to finance purchase (through private or nonprofit organizations) of health insurance which would go into effect upon retirement.

In its instruction to HEW, the committee says it is "very much aware" of the problems in paying hospital and nursing home bills for the aged, and notes that a number of bills had been introduced on the subject, and that some witnesses had emphasized that health insurance is "out of reach" of many older people. Then the committee report comments:

"Your committee believes, however, that more information on the practicability and the costs of providing this kind of protection through various methods should be available before it entertains any recommendation for legislation on the subject. A study of alternative ways of providing insurance against the cost of hospital and nursing home care for old-age, survivors, and disability insurance beneficiaries should be made.

"The alternatives explored should include among other proposals: a pre-payment plan under which persons would, during their working years, pay additional social security contributions which would be used to buy this type of insurance (to take effect when the individual becomes an old-age, survivors, and disability insurance beneficiary) from private and non-profit health insurance organizations; other methods of providing insurance against the cost of hospital and nursing home care under title II; and any other method which offers reasonable prospects for protecting old-age, survivors, and disability insurance beneficiaries against the cost of needed hospital and nursing home care. The study would include, for each of the several alternatives, an evaluation of (1) cost of the benefits and (2) administrative implications.

With the results of such a study available, the Congress will be in a better position to decide what legislative measures, if any, should then be taken to meet the problem."

The National Conference on Air Polution will be held November 18-20 in the Sheraton-Park Hotel, Washington, D. C.

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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Health Insurance . . .

What Do People Think of It? How Do They Use It? What Factors in Their Lives Influence Their Decisions? Survey Throws Some Light on Subject

TWO out of every five American families who are protected against the cost of illness or accident have used their health insurance in the past year to defray medical expenses, the Health Insurance Institute reported. A nationwide consumer survey of health insurance just completed, the Institute said, also shows that seven out of ten families who have such insurance have used it at some time during the period their policies were in force.

The study, conducted for the Institute by an independent research organization, was undertaken to obtain information on what people know and think about health insurance, how they use it, and also how such factors as age, income, education and place of residence are related to health insurance coverage. The survey is the first of its kind to be undertaken on a nationwide scale for insurance companies.

Results of the survey were announced recently at the annual meeting of the Health Insurance Association of America in Chicago by Albert I. Hermalin, assistant director, Division of Statistics and Research, Institute of Life Insurance, who served as consultant to the Health Insurance Institute on this project. Mr. Hermalin said the survey involved interviews with 2,000 families across the country, yielding information on more than 6,600 individuals.

About Coverage

On 53 per cent of all claims, the survey reveals, families received payment on all or most of the medical bill, while in 20 per cent of the cases payment was received for about three-quarters of the bill, and in 15 per cent of the claims, one-half of the total expenses were paid.

Some 78 per cent of the families using their health insurance expressed satisfaction with the service of the insuring organizations in paying benefits, according to the Institute survey, while 4 per cent were dissatisfied and 18 per cent had no definite opinion.

These figures, Mr. Hermalin pointed out, are consistent with the generally favorable attitude of the population toward health insurance which is revealed by the survey. Some 81 per cent of the people interviewed expressed a favorable attitude toward the idea of having health insurance for themselves, while 9 per cent were neutral in their comments and 8 per cent were unfavorable. Of the insured families, 90 per cent were favorable, and 55 per cent of the families without coverage expressed a favorable attitude.

Mr. Hermalin pointed out that the pattern of attitudes on this question is almost identical for those covered by Blue Cross-Blue Shield organizations and families protected through insurance companies. Nor is there significant variation, added the speaker, in this attitude among different income groups, or among families covered through group insurance plans and those with individual insurance policies.

It's Here To Stay

Public acceptance of health insurance is also reflected in the survey results on suggested improvements in plans or services. Some 25 per cent of the families had suggestions to make in this regard, 16 per cent gave no answer, and 59 per cent said they had no suggestions for improving health insurance plans or services.

Of the families with suggestions for improving services, 25 per cent desired more information on health insurance, while 20 per cent wanted more benefits in terms of dollars or number of days, and 14 per cent suggested lower premium costs. The responses were found to vary little by type of insuring organization.

"It would seem to be significant," Mr. Hermalin stated, "that the most frequently made suggestion expressed a desire for more information rather than a concern about prices, benefits, services, cancellation, claim service and the like. It indicates again the generally favorable feeling people have toward health insurance."

Mr. Hermalin said the survey indicates that the public does not perceive any essential difference between the health insurance provided by insurance companies and that offered by Blue Cross-Blue Shield plans. This is suggested, he added, by the fact that families who have Blue Cross-Blue Shield coverage, and those with insurance company policies, "tend to regard health insurance in almost identical ways."

"This means," he explained, "that they are equally favorable toward health insurance, they have suggestions to make with about the same

(Continued on Page 1230)



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(Continued from Page 1226)

frequency, their suggestions are similar, they are equally informed about health insurance, and so on."

Three Out of Four

Turning to the extent of coverage, Mr. Hermalin reported that survey figures are consistent with previously published data showing that nearly three out of four American families have some form of health insurance. In 73 per cent of all families, there is some health insurance coverage and in 60 per cent of all families every family member is protected. In 27 per cent of families, no one is insured, the survey points out. It further reveals that men, women and children are covered with virtually the same frequency, with 69 per cent of the men insured, 67 per cent of the women and 66 per cent of children under eighteen so protected.

In the selection of families to be interviewed, the survey, conducted for the Health Insurance Institute by National Analysts Inc. of Philadelphia, followed a method similar to that used by the U. S. Bureau of the Census in its sample interview surveys. The Institute study required approximately eight months to complete, with each interview lasting about one and one-quarter hours.

The Health Insurance Institute is the central source of information for the nation's insurance companies serving the public through voluntary health insurance.

New Program To Aid Basic Medical Research

To help support the search for new medical knowledge and to increase the number of trained medical researchers, the National Fund for Medical Education has established a Medical Research Program through which contributions from united funds, community chests, voluntary health agencies and other organizations will be channelled into basic research, Fund President S. Sloan Colt has announced.

The United Community Funds and Councils of America, whose local affiliates have expressed a desire to help support broad fundamental programs of basic medical research on a national level, have agreed to support this new research program.

It is our hope, Mr. Colt said, that the voluntary health agencies which have so generously supported the categorical research into specific diseases will also support this new program.

This expansion of the National Fund's program, Mr. Colt stated, will in no way affect its campaign among corporations to obtain support for the teaching budgets of the accredited medical schools in the United States.



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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio
(See Page 1121 for roster of officers.)

CUYAHOGA COUNTY

The Cuyahoga Medical Auxiliary has been active during the summer months. In the May meeting the following officers were installed: Mrs. Fred R. Rittinger, president; Mrs. Frank L. Meany, president-elect; Mrs. George Tischler, vice-president; Mrs. Thomas Manning, recording secretary; Mrs. Edward Marshall, corresponding secretary; Mrs. Joseph Crowley, treasurer; Mrs. John H. Atkins, assistant treasurer. Directors—Mrs. John Budd, Mrs. James Gavin, Mrs. William Nosik, Mrs. Myron Perlich, Mrs. George Petznick, Mrs. Kenneth Potter.

The Auxiliaries' first bowling league of 20 members closed with a luncheon at Caminati's. Mrs. Charles Reinacher, president of the league, awarded trophies to the leading team of Mrs. George Lockhart, Mrs. W. W. Faller, Mrs. Vincent Kaval, and Mrs. Roscoe Kennedy.

The league will bowl again in September with membership increased to 40 in East Cleveland and 20 in West Cleveland.

Auxiliary members continued their job of good public relations in the community. Mrs. George Tischler served as hospitality chairman for United Appeal at the meeting to help the Red Cross and Community Chest and plan for the Fall Campaign.

On May 24 the Academy of Medicine sponsored a group of 80 High School students through the medical school. The Auxiliary members served the boys lunch.

TRUMBULL COUNTY

Members of the Auxiliary to the Trumbull County Medical Society have for many years given of their time and money to aid the Student nurses at Trumbull Memorial Hospital in Warren.

This year's Student Nurse Committee had a picnic for all the student nurses on July 31. The picnic was held at the home of Mrs. T. P. Berry at Kinsman. Mrs. John Caldwell was co-chairman. Other members of the committee furnished transportation.

Neurosurgeon Goes to Los Angeles

Dr. Kenneth H. Abbott, former practicing physician in Columbus and assistant clinical professor of neurosurgery at Ohio State University, is now in Los Angeles where he is professor of neurological surgery at the College of Medical Evangelists, Los Angeles Section.

New Joint Council on Health Care of Aged Names Executive Secretary

The Joint Council to Improve the Health Care of the Aged has been named Howard I. Wells, Jr., of Chicago as its executive secretary, Dr. Edwin L. Crosby, the Council's interim secretary, reported. Dr. Crosby is also director of the American Hospital Association.

The establishment of the Joint Council was announced on April 8 by the four founding organizations—the American Dental Association, the American Hospital Association, the American Medical Association and the American Nursing Home Association.

Objectives of the Council were announced as "(1) to identify and analyze the health needs of the aged; (2) to appraise available health resources for the aged; and (3) to develop programs to foster the best possible health care for the aged regardless of their economic status."

Offices of the Council have been set up at 139 N. Clark St., Chicago.

Mr. Wells takes over his new post after being executive secretary of the American Association for Maternal and Infant Health since February 12, 1954. He took his baccalaureate at Northwestern University and did graduate study in social welfare administration at the University of Copenhagen in Denmark.

He has held positions with the Community Fund of Chicago, the Federal Council of the Churches of Christ in America, the American City Bureau, and the Illinois Division of the American Cancer Society.

University of Buffalo Announces Series of Fall Courses

The University of Buffalo School of Medicine has announced several fall postgraduate courses. Details may be obtained by writing the Department of Postgraduate Education, 3435 Main St., Buffalo 14, N. Y. The following short courses have been announced: September 17-18, "Use and Interpretation of Diagnostic X-Ray"; October 1-2, "Arthritis"; October 15-16, "Modern Laboratory Procedures in Clinical Practice"; October 22-23; "Recent Advances in Chest Diseases"; October 29-30, "Psychiatric Problems in General Practice."

Chest Physicians Certified

The American College of Chest Physicians awarded Fellowship Certificates to two Ohio physicians at its recent 24th annual meeting in San Francisco. They are Dr. Neil C. Andrews, Columbus, and Dr. Bernard L. Brofman, Cleveland.



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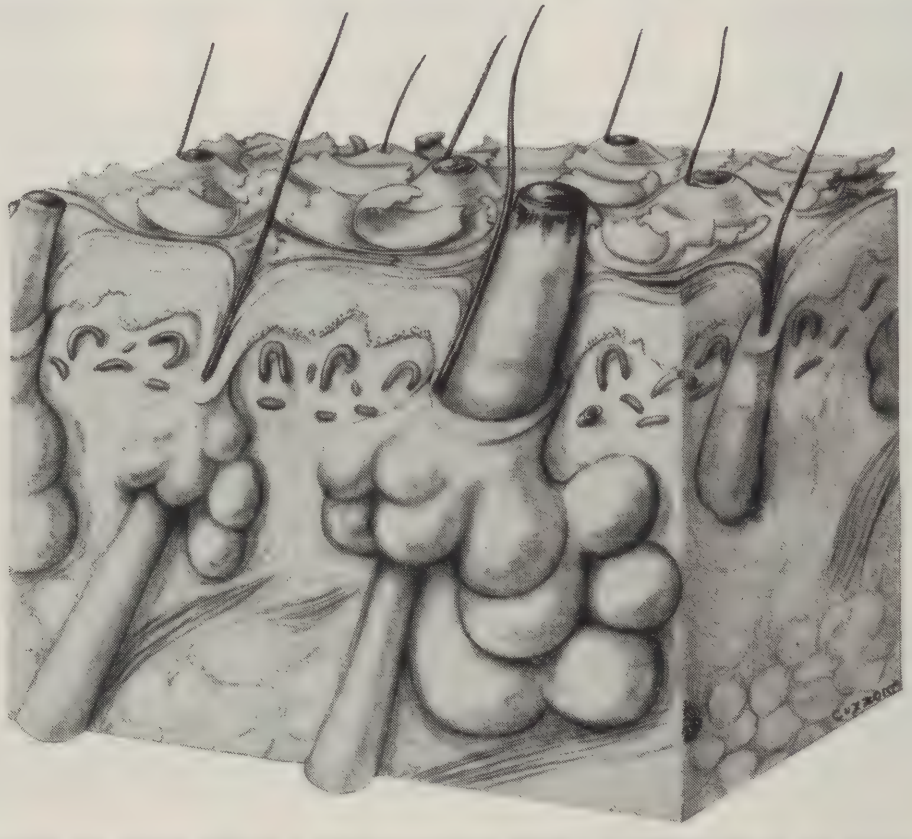
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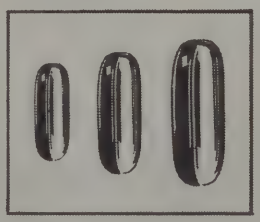
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Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

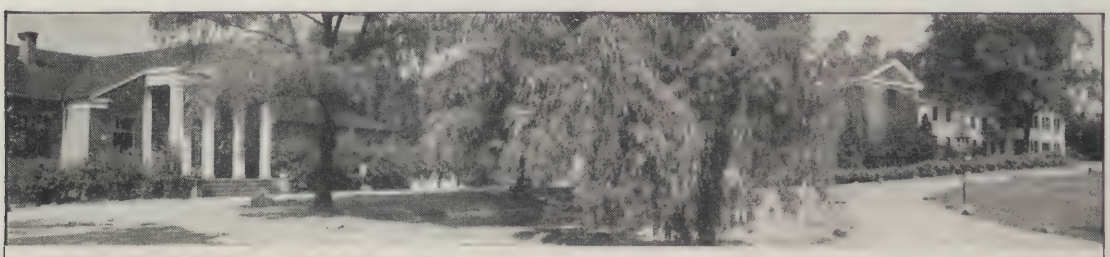
Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

Separate buildings for boys and girls, each with round-the-clock supervision of skilled personnel. Total enrollment 90. Catalog on request.

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A NON PROFIT CORPORATION

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A hospital for the treatment of Psychiatric Disorders. *Booklet available on request.*

JOHN H. NICHOLS, M. D., *Medical Director* G. PAULINE WELLS, R. N., *Admin. Director* HERBERT A. SIHLER, JR., Sec'y.

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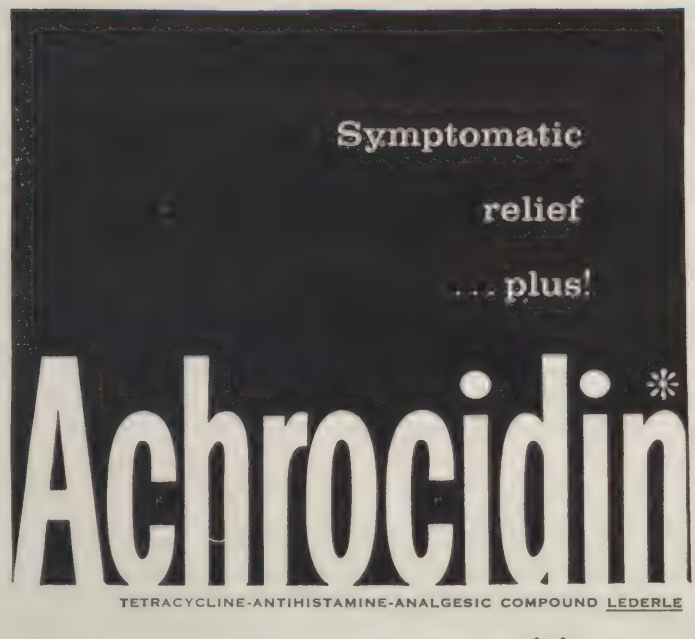
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pneumonitis

adenitis

sinusitis

otitis

bronchitis

COMBINES: Traditional components for relief of the annoying symptoms of early upper respiratory infections...

PLUS: Protection against bacterial complications often associated with such conditions.

TABLETS (sugar coated)
Each contains:

ACHROMYCIN* Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP (lemon-lime flavored, caffeine-free)
Each 5 cc. teaspoonful contains:

ACHROMYCIN* Tetracycline equivalent to Tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 fl. oz.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children adjusted according to age and weight.
Available on prescription only.

Lederle **LEDERLE LABORATORIES,** a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
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THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

ESTABLISHED 1873

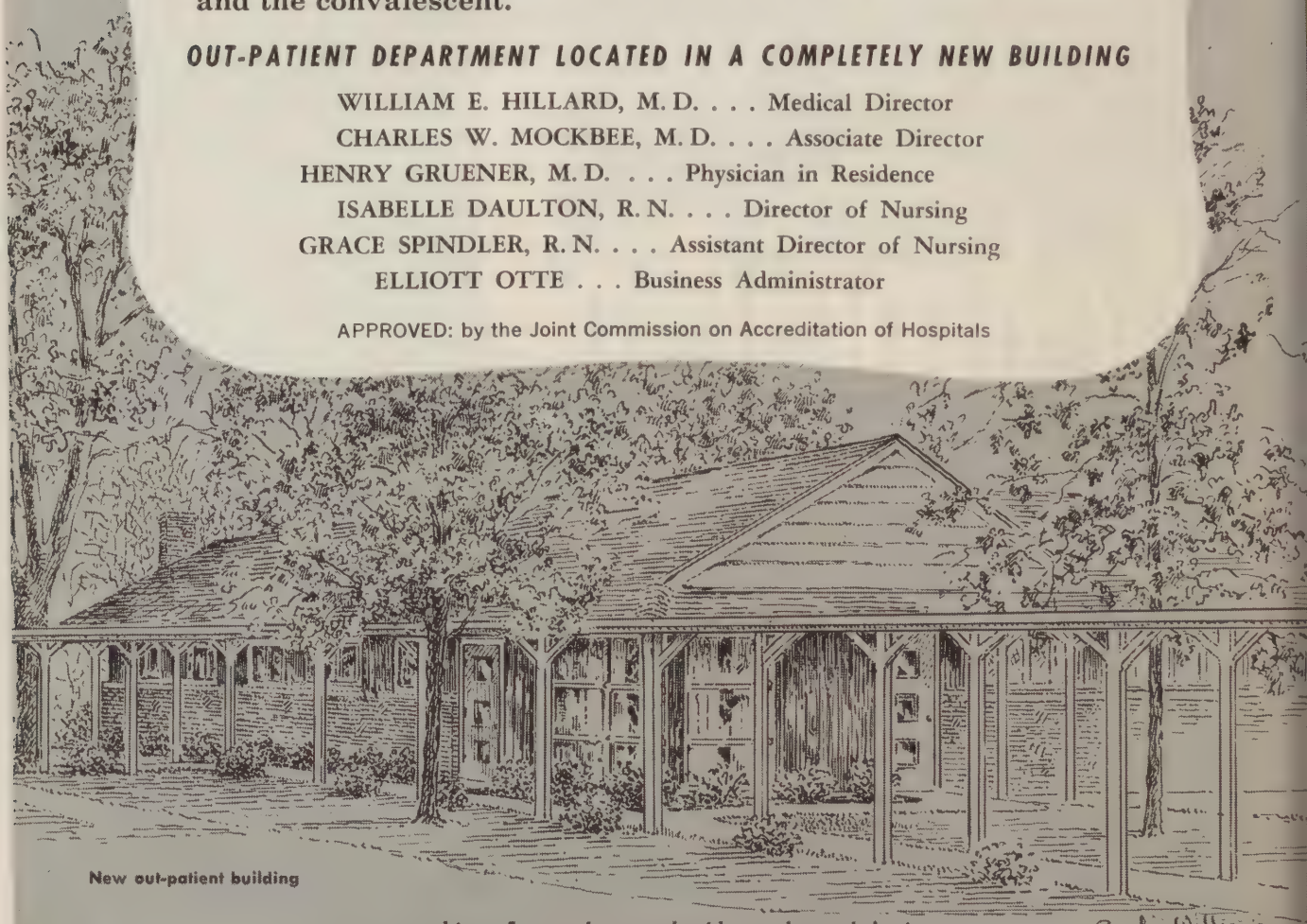
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- Equipped to provide all modern and accepted methods of treatment.
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OUT-PATIENT DEPARTMENT LOCATED IN A COMPLETELY NEW BUILDING

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for depression

▲Deprol▲†

Clinically confirmed in over 1,200 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation

► restores natural sleep

► reduces depressive rumination and crying

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function

► causes no excessive elation

► produces no liver toxicity

► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†Trade mark

Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N. J.*

For Speedier Return to Normal Nutrition

Meat...

in Inflammatory Conditions of the Colon

The physiologic depletion accompanying acute infectious and inflammatory conditions of the bowel makes replacement therapy the key to nutritional rehabilitation.

In addition to the loss of important electrolytes, such as potassium and sodium, large amounts of protein are lost in the fluid, blood and exudate from the bowel. In the acute state of such affections, utilization of what protein can be ingested is further affected by increased protein catabolism and by impairment of certain hepatic functions.

Dietary rehabilitation must be carried out within the framework of a diet restricted in fiber and in irritating substances. Foods allowed must be easily digested and appetizingly and attractively prepared to encourage eating.

Tender lean meats—finely ground in the initial diet and later served in a wide variety of appealing ways—can be an important source of the protein and minerals required by the convalescing patient.

Meat fits admirably into the requirements of the permitted diet not only because of its taste, digestibility, and physical characteristics, but also because of its contribution of high quality protein, the minerals potassium, iron, phosphorous, sodium, and magnesium, and all the known B vitamins.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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Main Office, Chicago...Members Throughout the United States

They all went to the doctor . . .

I was too much

I was too little

I was simply two

And I was getting brittle

With my anemia, I could never make it up that high



AMPLUS®
for sound obesity management
dextro-amphetamine plus vitamins and minerals

STIMAVITE®
stimulates appetite and growth
vitamins B_1, B_6, B_{12}, C and L-lysine

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a nutritional buildup for the OB patient

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when anemia complicates pregnancy

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one capsule a day, for all treatable anemias

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when more than a hematinic is indicated

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. . . and he solved their problems with a nutrition product from

ROERIG Rx

New York 17, New York
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

in cases of tension

Serpate®

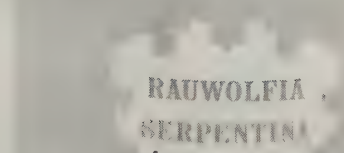
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. . . the preferred drug where anxiety or emotional agitation must be controlled

. . . provides sedation without hypnosis, a sense of relaxed well being and tranquility

. . . effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies



in cases of hypertension

Rauval®

(Rauwolfia Serpentina, Vale)

. . . double assayed to insure optimal therapeutic effect

tested chemically to insure total alkaloid content

tested biologically to insure uniform hypotensive action

. . . ideal therapy in labile and moderate hypertension or as adjunctive therapy in severe hypertension

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VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*

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STOP

running noses and open stuffed noses orally

Relief in minutes...lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ."* The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

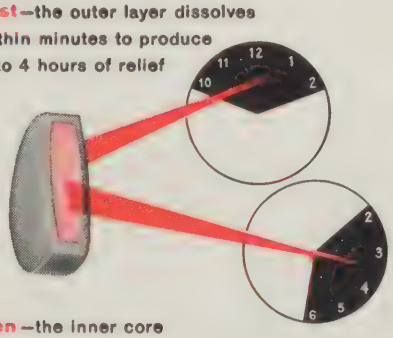
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

Each timed-release TRIAMINIC *Tablet contains:*

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

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Each timed-release tablet keeps the nasal passages clear for 6 to 8 hours— provides "around-the-clock" freedom from congestion on just three tablets a day



Also available: Triaminic Juvelets, timed-release, half-dosage tablets; Triaminic Syrup, for children and those adults who prefer a liquid medication.

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timed-release tablets

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VARIDASE* BUCCAL TABLETS

Streptokinase-Streptodornase Lederle

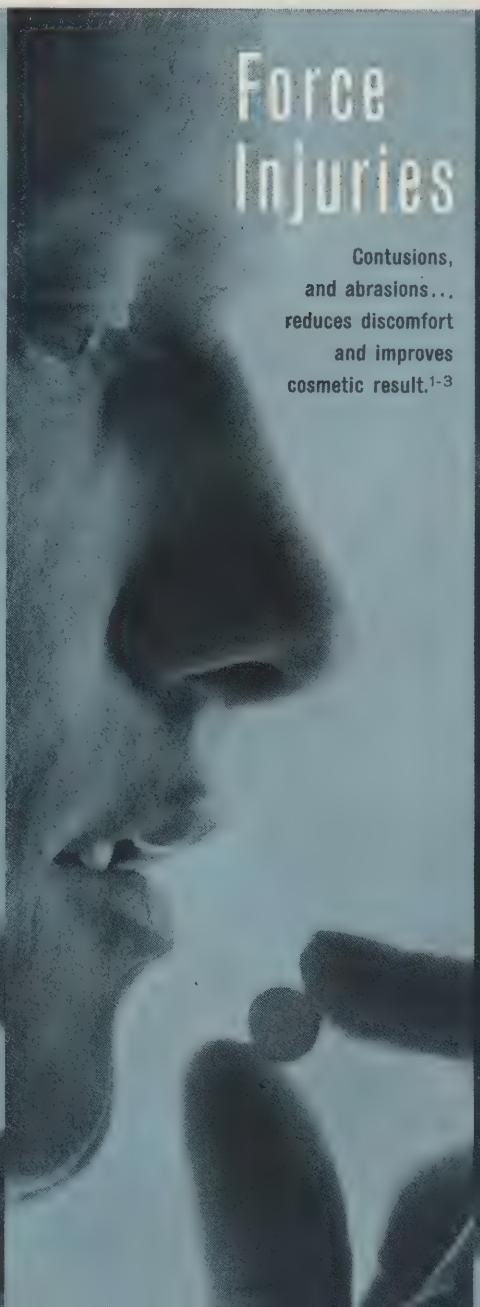
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References: 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1069 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 166:478 (Feb. 1) 1958. 3. Davidson, E; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. II: 1 (June) 1958 *Reg. U. S. Pat. Off.



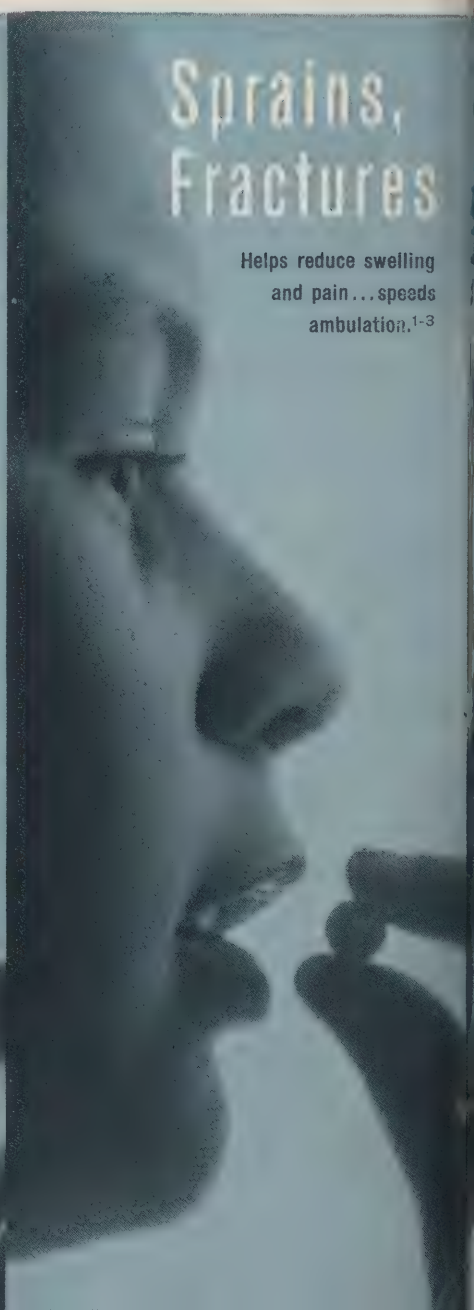
In Sinusitis

Helps promote drainage... hastens patient's relief... reduces mucosal swelling.[1]



Force Injuries

Contusions, and abrasions... reduces discomfort and improves cosmetic result.[1-3]



Sprains, Fractures

Helps reduce swelling and pain...speeds ambulation.[1-3]

TO ACCELERATE THE RECOVERY PROCESS

Established Efficacy and Safety: For five years VARIDASE, in parenteral form, has been used with success in many thousands of cases. Its ability to control inflammation, swelling and associated pain, aid penetration of antibiotics, and hasten healing has been demonstrated in such conditions as severe trauma, infected ulcerations, and following extensive surgery.

Now, Parenteral Effectiveness . . . Simple Buccal Route: New VARIDASE Buccal Tablets give your patients the benefits of systemic VARIDASE therapy without the inconvenience of repeated injections. Absorbed through the buccal mucosa in fully effective amounts, VARIDASE Buccal Tablets may be used as practical adjunctive therapy in your practice within these broad classifications:

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Each VARIDASE Buccal Tablet contains 10,000 Units Streptokinase and 2,500 Units Streptodornase.

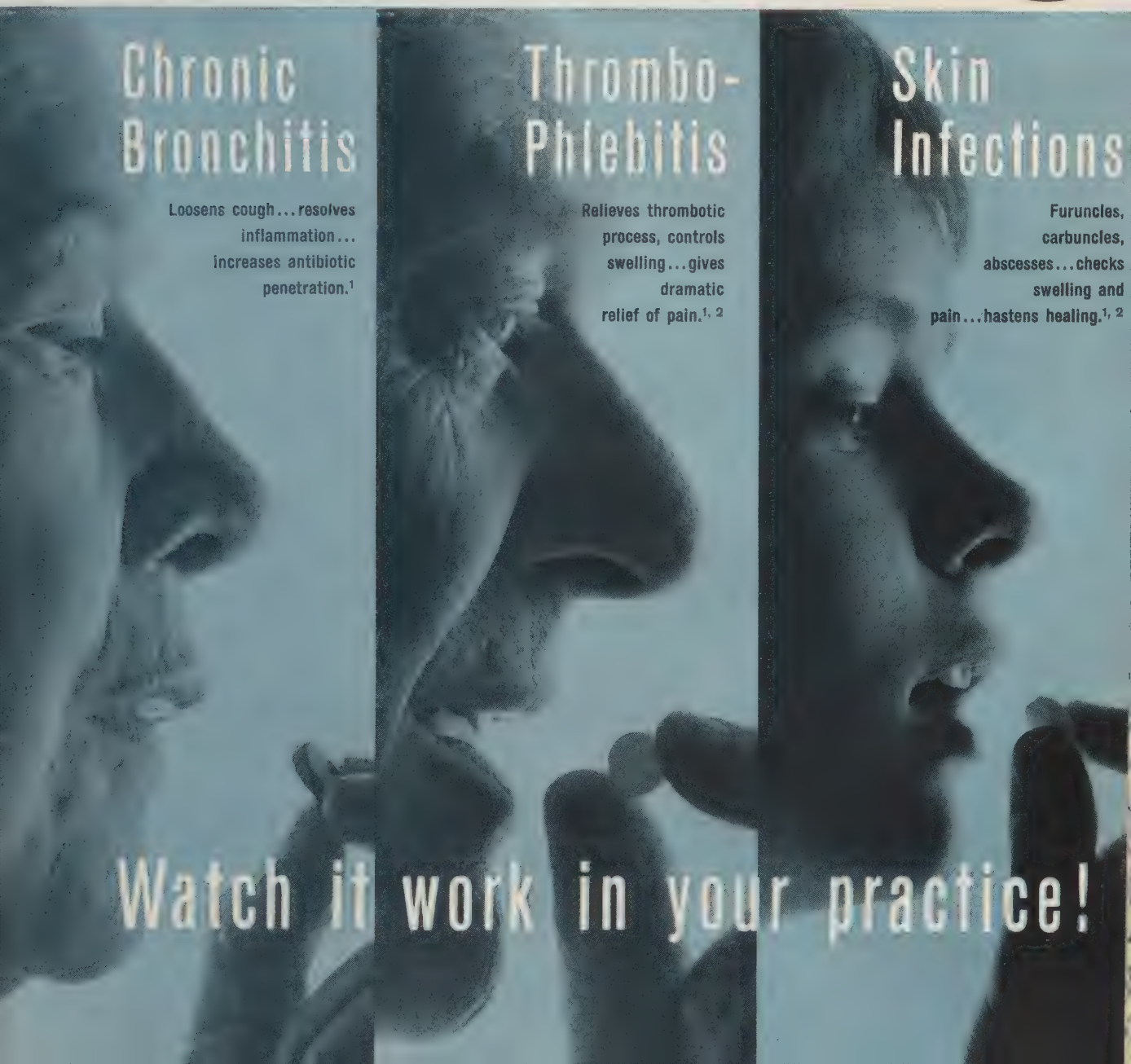
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The Flavor Remains Stable down to the last tablet.

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SOYALAC helps solve the feeding problem of prematures and infants requiring milk-free diet.

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Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.



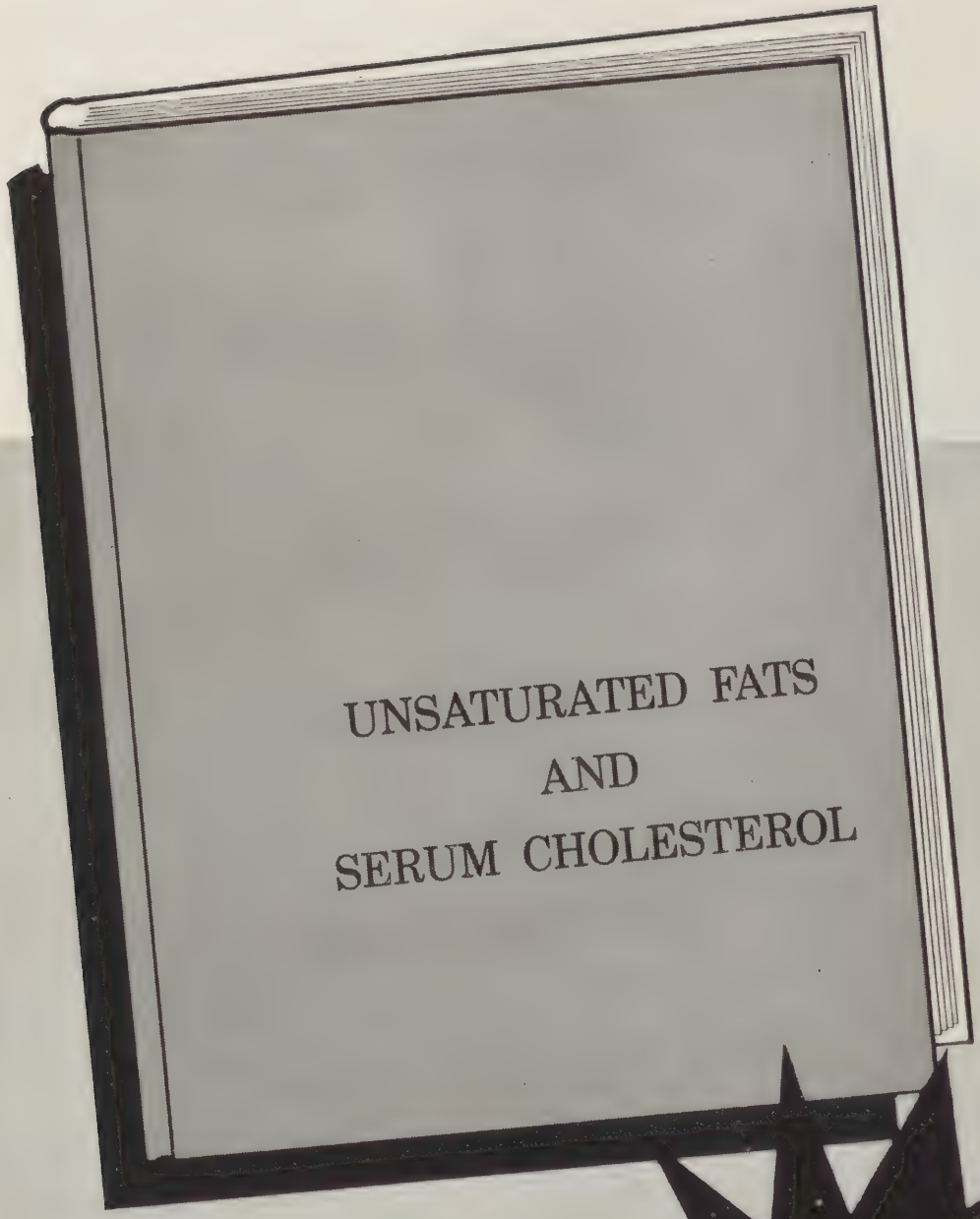
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A request on your professional letterhead or prescription form will bring to you complete information, and a supply of samples. Please address the Loma Linda Food Company, Arlington, California, or Mount Vernon, Ohio.

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Just off the press . . . send now for your FREE copy

"Unsaturated Fats and Serum Cholesterol"

...a review of the latest Concepts and Results of Current Research

Now ready for distribution to physicians as a special service by Corn Products Refining Company, this book supplements and supersedes the 1957 monograph "Vegetable Oils in Nutrition" and provides a broader coverage of this important subject.

This new book is the most up-to-date annotated bibliography on current research pertaining to:

1. The origin and behavior of cholesterol in the human body;
2. The effect of different dietary fats on serum cholesterol levels;
3. The nature of the active components in vegetable oils;
4. Suggestions for practical diets.

As a regular part of daily meals Mazola® Corn Oil can be used for control of serum cholesterol levels

MAZOLA CORN OIL, a natural food and a superior salad and cooking oil, used as part of the daily diet, can be helpful in the control of serum cholesterol levels.

Extensive clinical findings now show that serum cholesterol levels tend to be lower when an adequate amount of MAZOLA CORN OIL is part of the daily meals... high levels are lowered, normal levels remain normal.

MAZOLA...the only readily available vegetable oil made from golden corn oil... is rich in the important unsaturated fatty acids. 85% of all the fatty acids in MAZOLA are unsaturated and 56% of the fatty acid content is linoleic.

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Each Tablespoonful of Mazola* Corn Oil Provides Approximately 126 Calories—and:

Linoleic Acid	7.4 Gm.
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Typical Amounts Per Diet

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
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Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

American Association of Medical Assistants, Palmer House, Chicago, October 31-November 2.

Columbus Academy of Medicine, Clinic Day, Columbus, November 1.

Eighth Councilor District, Annual Medical Meeting, Zanesville Country Club, Zanesville, October 2.

Industrial Medical Association of Pittsburgh, Sheraton-Mayflower Hotel, Akron, September 19.

Mississippi Valley Trudeau Society, Dayton, October 17.

Montgomery County Medical Society Founders' Day, Biltmore Hotel, Dayton, October 3.

National Institute of Arthritis and Metabolic Diseases, Session on Rheumatic Diseases, Ohio State University Campus, Columbus, October 19.

Ohio Academy of General Practice, Annual Scientific Assembly, October 1-2, Toledo.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

University of Cincinnati College of Medicine, Postgraduate Course in Heart Disease, Cincinnati, September 3-6.

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

Licensed Rest Homes in Ohio. Division of Social Administration, Ohio Department of Public Welfare, has printed a new list of licensed rest homes. Write Division of Social Administration, Oak and Ninth Streets, Columbus, Ohio.

Healthful School Living. This joint AMA-NEA publication concerns school environment and completes a trilogy, the two former being health education and school health services. ($5) Write AMA Bureau of Health Education, 535 North Dearborn Street, Chicago, Ill.

Mental Health: A Ford Foundation Report. This pamphlet presents a general, nontechnical account of the Ford Foundation's work in the field of mental health. Write Ford Foundation, Office of Reports, 477 Madison Avenue, New York 22, New York.

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Classified Advertisements

Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows: Box (insert number), c o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

NEW MEDICAL CENTER opening within 30 days in Solon, Ohio, fastest growing industrial area in the State. Desirable location for G. P., Pediatrician, Ophthalmologist, Radiologist and Surgeon. Contact Norton Norr, 2177 S. Taylor Rd., University Heights 18, Ohio. FA 1-0190.

OPPORTUNITY TO TAKE OVER GENERAL PRACTICE established 12 years ago in community of 12,000. Excellent schools; open staff hospital. Box 105 c/o Ohio State Medical Journal.

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MEDICAL AND DENTAL OFFICES available in a new ten-unit all airconditioned medical building. Contact A. W. Brownstone, M. D., Painesville, Ohio.

PHYSICIAN'S OFFICE FOR RENT. Well established general practice. Office equipment and furniture for sale. Mrs. Robert A. Thornton, 43 E. Tompkins St., Columbus 2, Ohio; Phone AM 2-9829.

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DOCTOR'S OFFICE FOR RENT: Vacated due to death. A perfect setting for general practice. This 5-room office is fully equipped; heat furnished; elevator service; private parking. Located in physicians' building. May be rented with or without equipment. City pop. 45,000; excellent hospital facilities. Medical laboratory in building. For information call: Jesse J. Hedges, West Village Dr., Newark, Ohio; Phone DIamond 4-4940.

BUSY GENERAL PRACTICE to take over in October. Southeast Ohio, 3000 population, fully equipped office for sale or rent, 3 miles away from county seat with 2 hospitals (open staff) and good schools; new highway. For details write Box 104, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER for furnished office located next to hospital (45 bed capacity) town approximately 10,000 population. Available now. Unlimited established practice. (Grossed $50,000 last year.) No practice to buy. Contact: Gibbons Hospital Supt., Celina, Ohio.

PEDIATRICIAN: Wonderful opportunity to locate a private practice in one of the most desirable sections of Columbus. There is a real need for a qualified pediatrician in this district; convenient to all hospitals; space still available in a brand new Medical Building to be completed in early 1959. Top notch x-ray and laboratory facilities are available on the premises; specialists in most other fields in building. Address Box 103, c/o The Ohio State Medical Journal.

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PHYSICIAN'S OFFICE FOR RENT: Opportunity for man or woman physician who wishes to practice general medicine without surgery. County seat town of 7600 with 14,000 within radius of 6 miles and only 6 doctors. Has 5 rooms, has been physician's office for many years. James W. Long, M. D., Bryan, Ohio.

Nursing in Disaster

The National League for Nursing, Inc. has received a grant of $80,000 from the ODCM to initiate a project to demonstrate ways of preparing nurses for mass casualty and other civil defense nursing roles. The objective is to determine curriculum content in nursing in disaster for all types of nursing education programs and for inservice training programs in hospitals. The project, which will last 18 months, is an initial step in the preparation of a plan for nursing education in national defense.

Better service for veterans and physicians in the Veterans Administration hometown medical care program is expected when conversion to a punch card system is completed.

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(Including Radium Applicators)

FOR ALL MEDICAL PURPOSES

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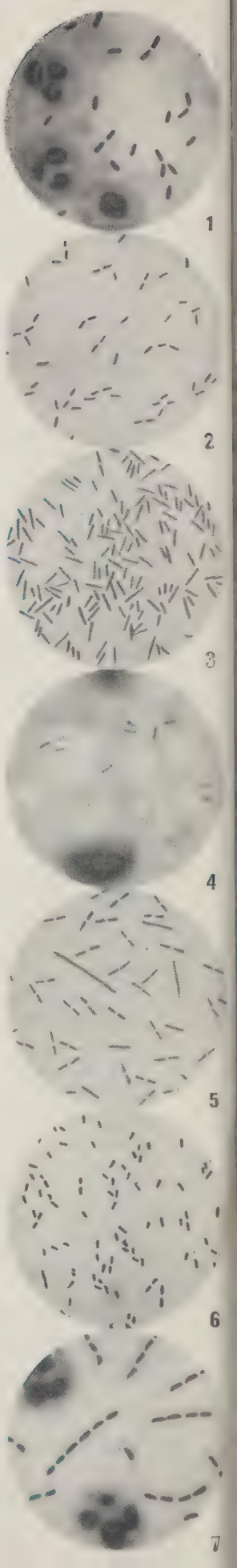
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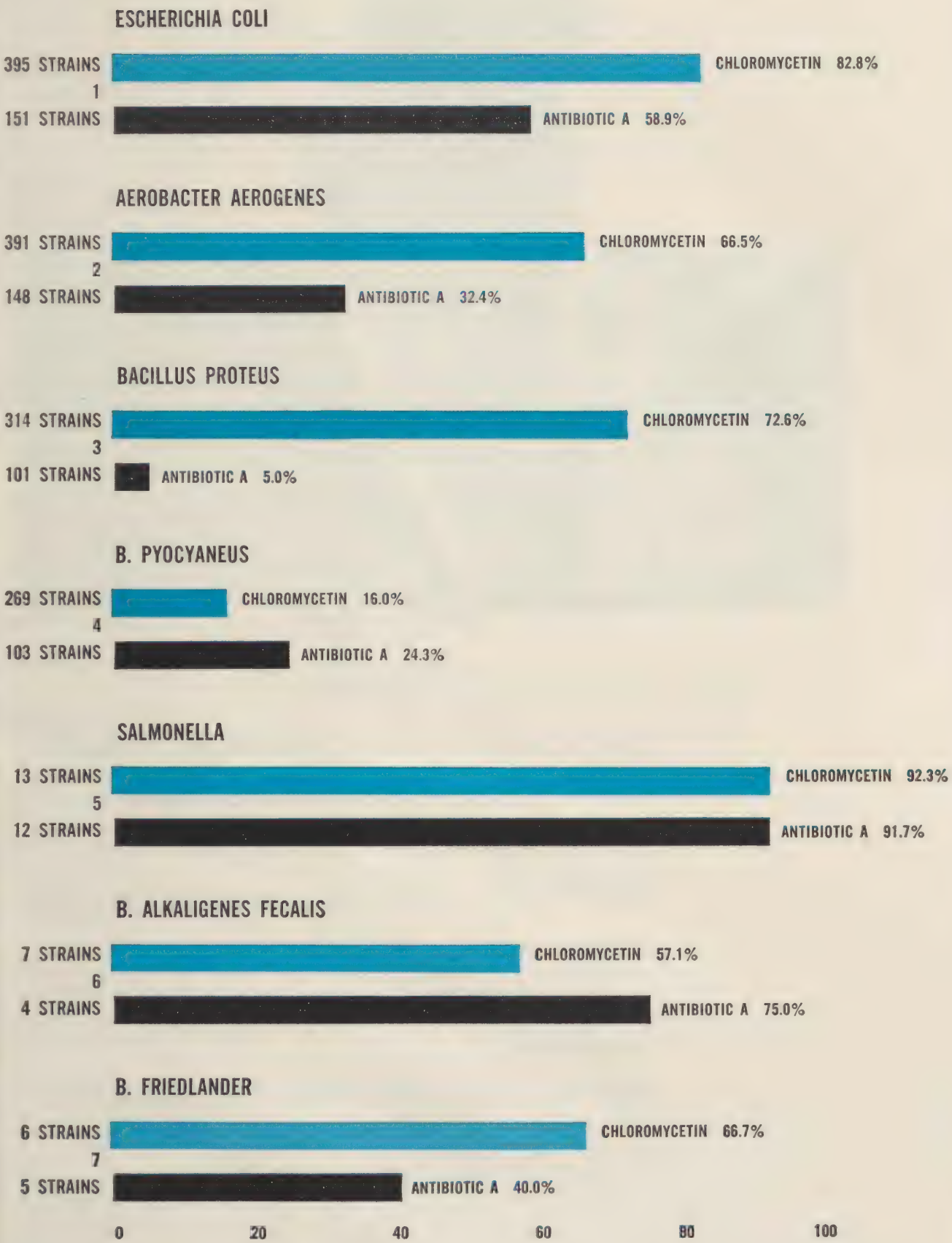
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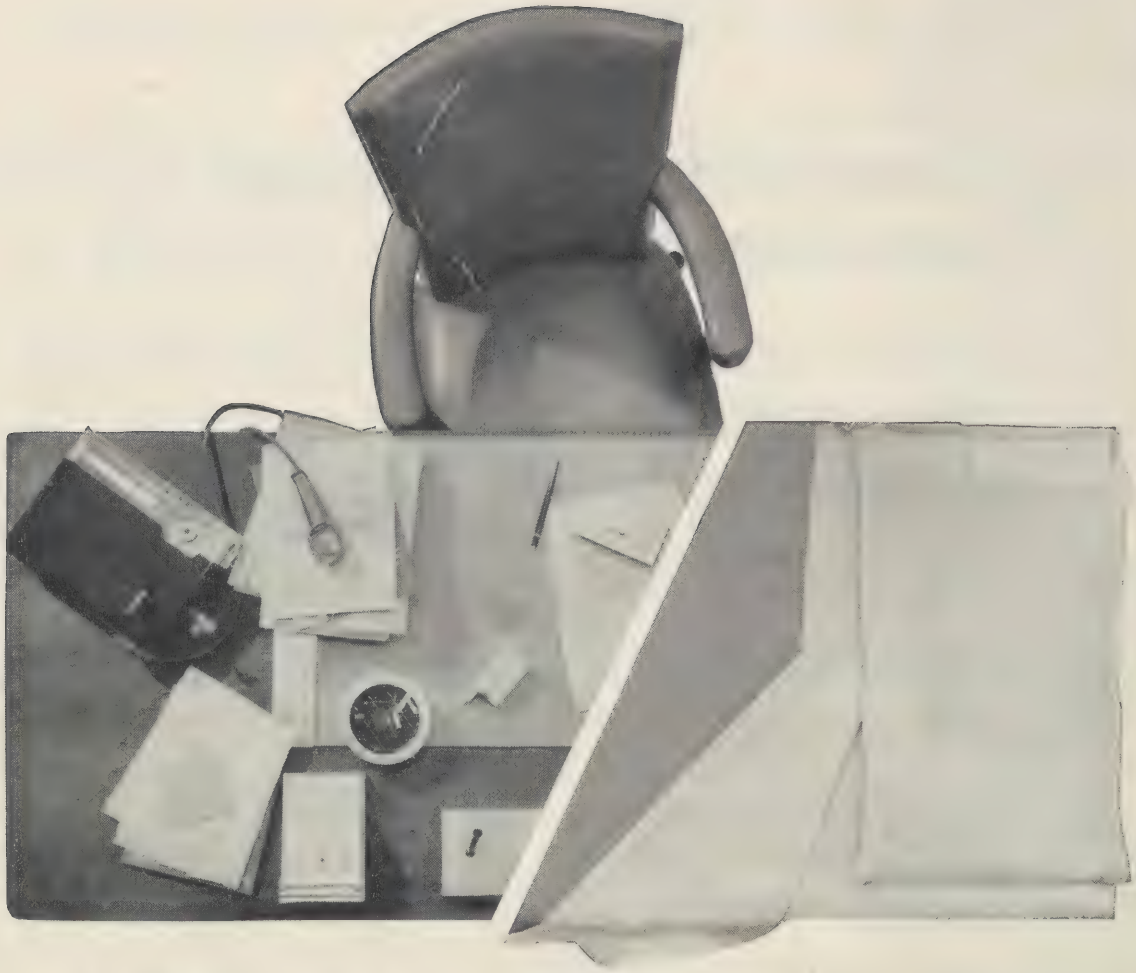
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IN VITRO SENSITIVITY OF SEVEN GRAM-NEGATIVE PATHOGENS TO CHLOROMYCETIN AND TO ANOTHER WIDELY USED ANTIBIOTIC*



*Adapted from Schneierson.[1]



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Vol. 54 October, 1958 No. 10

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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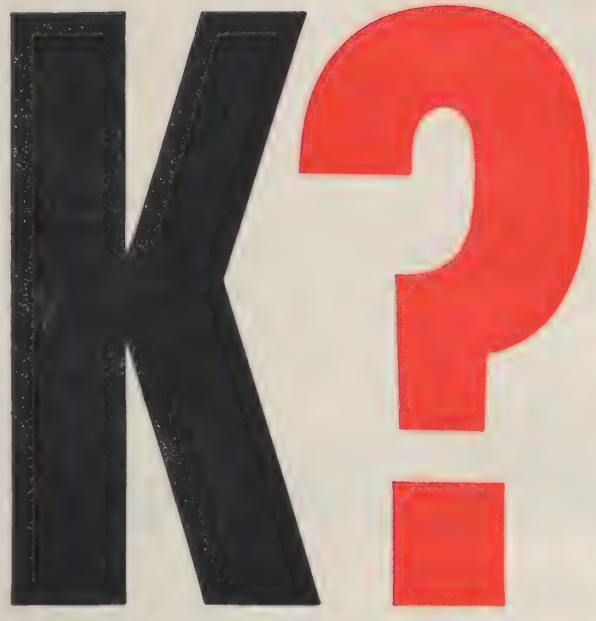
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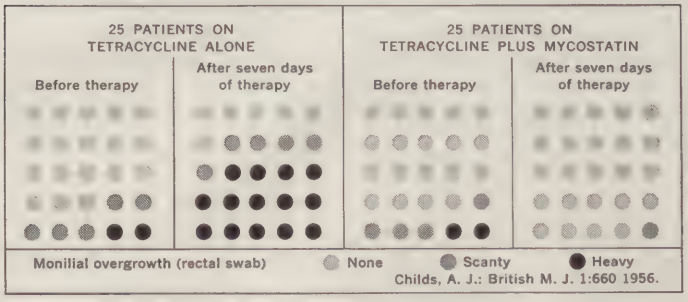
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HENRY—Tony P. Delventhal, President, Napoleon; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday, monthly.

LUCAS—Harvey C. Gunderson, President, Toledo; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly.

OTTAWA—Cyrus R. Wood, President, Port Clinton; Robert W. Minick, Secretary, Oak Harbor. 2nd Thursday, monthly.

PAULDING—Edythe C. Pritchard, President, Paulding; D. E. Farling, Secretary, Payne. 3rd Wednesday, monthly.

PUTNAM—Joseph J. McHugh, President, Ottawa; Will W. Moody, Secretary, Vaughnsville.

County Societies' Officers and Meeting Dates (Continued)

SANDUSKY—Edwin C. Swint, President, Fremont; Paul E. Burson, Secretary, Bellevue. 3rd Wednesday, monthly.

WILLIAMS—David S. Brown, President, Stryker; Harvey F. Doe, Secretary, Edgerton. 3rd Tuesday, monthly.

WOOD—Stewart J. Smith, President, Bowling Green; Richard L. Pearse, Secretary, Bowling Green.

FIFTH DISTRICT

ASHTABULA—Walter J. Brown, President, Conneaut; Robert J. Zimmerman, Secretary, Conneaut. 2nd Tuesday, monthly.

CUYAHOGA—Chester R. Jablonoski, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. 3rd Tuesday monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—David Danenberg, President, Bridgeport; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vorhies, Secretary, Scio. Meetings quarterly.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Shaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Don R. Johnson, President, Nelsonville; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Richard R. Hille, President, Marietta; Roy M. Meredith, Secretary, Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Ralph B. Burner, President, Gallipolis; George E. Files, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

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SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. Second Monday, monthly.

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DELAWARE—Mary K. Kuhn, President, Ashley; Edward C. Jenkins, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, London; Paul G. H. Wolber, Secretary, London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Harold V. Marley, President, Ashland; Myrtle A. Shilling, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday monthly.

HOLMES—Luther W. High, President, Millersburg; Olive F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—Owen J. Nicholson, President, Norwalk; John L. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria; Mrs. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Charles F. Curtiss, President, Bellville; John J. Clark, Secretary, Mansfield.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.

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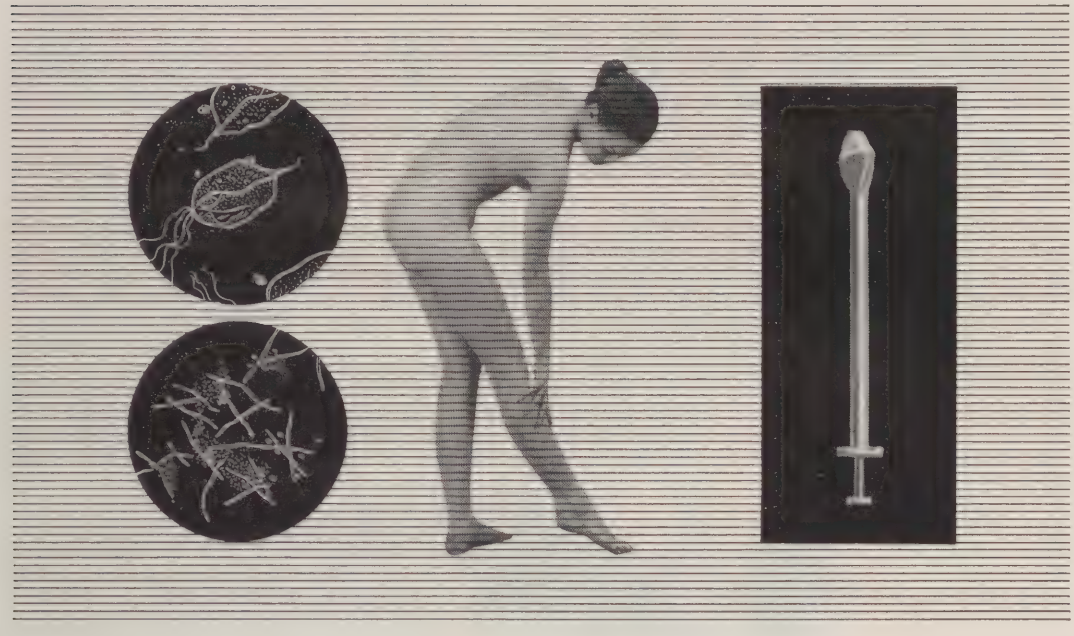
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1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157*:126 (Jan. 8) 1955.

2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25*:182 (Feb.) 1956.

3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51*:1494 (June 15) 1956.

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The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

The Student-Physician; Introductory Studies in the Sociology of Medical Education, edited by Robert K. Merton, George G. Reader, M. D., and Patricia L. Kendall. ($5.00, Published for the Commonwealth Fund by the *Harvard University Press, Cambridge 38, Mass.)* This is a pioneer study of the sociological and the psychological problems inherent in the development of young doctors and examines the fundamental, personal questions which concern the medical students and those in charge of medical education and attempts to outline the urgency and desires that lead young men to study medicine.

Essays in Metabolism, edited by Louis G. Welt, M. D. ($6.50, *Little, Brown and Company, Boston 5, Mass.)* This is the John Punnett Peters number of the *Yale Journal of Biology and Medicine.* It is an unusual festschrift. Rather than a miscellaneous collection of unimportant papers dug out of dusty files by each and every former student, this is a collection of essays prepared especially for this volume which cover in a general area of clinical biochemistry half a dozen subjects which Dr. Peters made his own. This belongs in the library of everyone and every institution that is interested in biochemistry.

Understanding Your Patient, by Samuel Liebman, M. D. ($5.00, *J. B. Lippincott Company, Philadelphia 5, Pa.)* It is the third in a series of aims at helping the medical practitioner understand his patients. Recent studies indicate that as high as 80 per cent of the patients appearing for medical advice have shown significant psychological factors in the genesis of their complaint. This book devotes itself to putting emphasis on the examination and treatment of individuals from this vital point of view.

In Search of Man, by André Missenard. ($5.95, *Hawthorn Books, Inc., New York 11, N. Y.)* This French scientist and Alexis Carrel, collaborator, in the foundation for the study of human problems present for the first time their studies of the influence of heredity and environment and the effects of spiritual forces for the formation of man's personality and the society in which he exists. Those who profited by Dr. Carrel's **Man the Unknown** will enjoy and profit by this book.

The Chemical Dynamics of Bone Mineral, by William Neuman and Margaret W. Neuman. ($5.00, *University of Chicago Press, Chicago 37, Illinois.)* This book is an up-to-date summary on bone mineral which resolves the old dilemma of blood bone equilibrium. At last this strange paradox finds its logical resolution in the summary of current information on how these physiological processes are controlled.

General Diagnosis and Therapy of Skin Diseases, by Herman Werner Siemnes, M. D., translated by Curt Wiener, M. D. ($10.00, 375 Illustrations. *University of Chicago Press, Chicago 37, Illinois.)* The author presents basic dermatological principles clearly and succinctly and illustrates these principles with hundreds of close-up photographs taken under his direction at the University of Leiden in Holland.

Practical Use of the Office Laboratory and X-Ray Including the Electrocardiograph, by Paul Williamson, M. D. ($10.75, *The C. V. Mosby Company, St. Louis 3, Mo.)* This book is designed to make possible the maximum benefit of the office laboratory thus greatly increasing the scope of office practice and adding to diagnostic accuracy. It is for the home-trained technician with a minimum of equipment.

Health Through Nutrition, by Lelord Kordel, Sc. D. ($3.50, *World Publishing Company, Cleveland 2, Ohio.)* The author, a well-known lecturer on nutrition, and a student of biochemistry, gives us popular instruction on how to live long and like it, covering both our mental and physical health as it is related to our nutrition.

The Preservation of Youth, by Moses Maimonides. ($2.75, *Philosophical Library, New York 16, N. Y.)* A translation of Maimonides' essays on health.

The Physiology of Man, by L. L. Langley, Ph. D., and E. Cheraskin, M. D. ($6.95, Second edition, *McGraw-Hill Book Company, Inc., New York 36, N. Y.)* Presenting the basic physiological processes in an integrated and meaningful pattern.

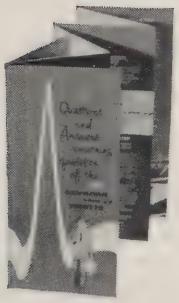
Year Book of Obstetrics and Gynecology: 1957-58 Series, edited by J. P. Greenhill, M. D. ($7.50, *The Year Book Publishers, Chicago, Ill.)* This book is up to its usual standard of 589 pages crammed full of reports from the literature with editorial comment.

Year Book of Pediatrics: 1957-58 Series, edited by Sydney S. Gellis, M. D. ($7.50, *Year Book Publishers, Chicago 11, Ill.)* Here we have



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370 pages abstracted from the current literature with sound editorial directional comment.

The Epileptic Seizure, by Cosimo Ajmone-Marson, M. D., and Bruce L. Ralston, M. D. ($6.00, *C. C. Thomas Publisher, Springfield, Ill.)* This book discusses the functional morphology and diagnostic significance of such seizures and gives a clinical electrographic analysis of Metrazol®-induced attacks. It presents a pattern of the entire epileptic seizure in detail and places emphasis not only upon the different signs but also upon their temporal relationship in the course of the attack.

Borderline Cases of Hodgkin's Disease, by L Offerhaus. ($4.50, *Gregory Lounz, 11 E. 45th Street, New York 17, N. Y.)* The difficulties encountered in discussing borderline cases of Hodgkin's Disease are several, and the subject abounds in literary reviews. Grossly, the publications can be divided into two categories—the German studies from Sternberg's first publication in 1898 until his death in 1936. Thereafter, the interest in lymphoid tumors dwindled in Germany and was taken over by American workers and Jackson and Parker culminated their efforts in their well known text in 1947. Recently there have been several revivals of interest in Europe. This book is a definite contribution to the compromising of opinion with regard to nomenclature and classification.

Extensile Exposure, by Arnold K. Henry, M. D., Dublin. ($10.00, 2nd edition, *Williams & Wilkins Company, Baltimore 2, Md.)* Bone carries our anatomy and forms its central fact, and bone wherever possible is made the core of each exposure. Even the few confined to nerves and vessels bring in a glimpse of skeleton and some of these (though well rehearsed in other books and easily accessible) are borrowed here again. They form the roots from which exposures spread and serve like roots to bind irrelative surroundings. It is a book that those who have need of exact knowledge of anatomy will enjoy and profit from reading.

One Surgeon's Practice, by Frederick Christopher, M. D. ($4.00, *W. B. Saunders Co., Philadelphia 5, Pa.)* This book records some personal observations and experiences, not only in the preparation for and the development of an average general surgical practice but also in the daily practical and detailed conduct of such professional work. Included are anecdotes and illustrated examples. The author, of course, is the editor of well known surgical textbooks.

The Spine Jack Operation for Scoliosis, by H. Leslie Wenger, M. D. ($2.00, *H. Leslie Wenger, M. D., 44 Gramercy Park North, New York 10, New York.)* Increasing divergent views and contradictory opinions concerning operations for this condition continue. Here we have the author's experience and his attitude toward the various operating procedures.

Modern Science and the Nature of Life, by William S. Beck. ($5.75, *Harcourt, Brace and Co., New York 17, N. Y.)* Life scientists are on the verge of the greatest break-through of all time. If the work now going on in biology bears fruit, scientists may soon bring into being the first living thing in the laboratory. Study of the simplest living thing, the viruses of the chemistry of the various living cells and the genes, the basic particles of which determine our heredity underlie the fundamental research in the question raised by this book. The author is a doctor of medicine and a research scientist in his own right.

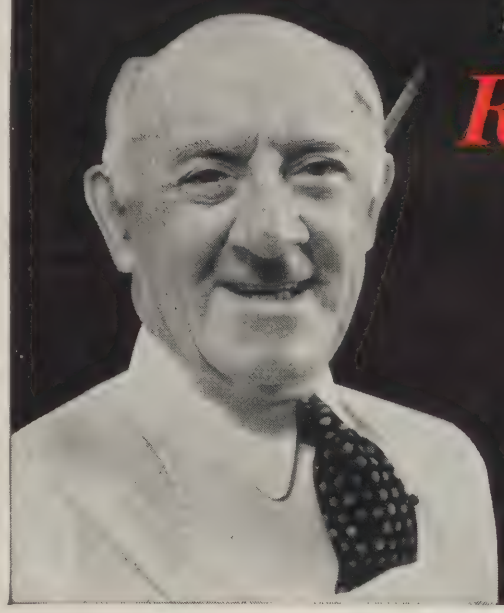
Implementation of the Nursing Curriculum in the Clinical Fields, by Edna H. Treasure, R. N. ($4.50, *The Catholic University of America Press, 620 Michigan Ave., N. E., Washington 17, D. C.)* It is the proceedings of a Workshop on this subject which was held in June 1956. The purpose of this Workshop was to provide an opportunity for the discussion of mutual problems which exist in the nursing service and the nursing education personnel who work together with students in the patient situation in hospitals.

The Conquest of Loneliness, by Eric P. Mosse, M. D. ($3.75, *Random House, Inc., New York 22, N. Y.)* With the tools of his psychiatric and psycho-analytic experience, the author describes the facts, the defense mechanisms and the possible solution of mankind's most harassing problem—loneliness. Loneliness seems to be a characteristic and inescapable malady of modern man. It masquerades behind all kinds of symptoms; it disguises itself in all kinds of devious ways. The author attempts to give us an understanding out of the depths of his experience.

The Glamourway Reducing Handbook, by Betty Dean. ($2.75, *Comet Press, New York 14, New York.)* This reducing handbook written by one of the well known dietitians and experts in foods is unique and well planned for the readers who want to get the information which it contains.

The Development of the Child: A Guide for Parents, Teachers, Students and Others, by Agatha H. Bowley, Ph. D., with a Foreword by D. R. MacCalman, M. D. ($3.00, fourth edition, has 84 photographs; *E. and S. Livingstone, Ltd., Edinburgh,* distributed in U. S. A. by *Williams and Wilkins Co., Baltimore, Md.)* This latest edition

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Ford, R. V., and Moyer, J. H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. 23:41 (Jan.) 1958.

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contains new material on the effects of separation on young children and references to modern education and school methods. It outlines some of the most recent developments in our knowledge and attitudes toward the matters of child care as well as including pertinent material on the play of young children and enlarging the section on adolescence.

Medical and Public Health Laboratory Methods, successor to the fifth edition of **Laboratory Methods of the United States Army,** by James S. Simmons, M. D., and Cleon J. Gentzkow, M.D. ($18.50, 115 engravings, 9 colored plates, *Lea and Febiger, Philadelphia 6, Pa.)* This sixth edition represents the cooperation of 35 authorities who have recorded their experiences in handling thousands of specimens under conditions enabling complete control. This edition also contains an immense amount of new subjects and tests.

Foot Troubles, by T. T. Stamm. ($4.75, *Philosophical Library, New York 16, N. Y.)* This is a short but comprehensive illustrated survey valuable to all foot sufferers, chiropodists, shoemakers, athletes and medical auxiliaries of every kind.

Vitamin A, by Thomas Moore, Sc. D. ($14.00, *Elsevier Publication, Van Nostrand Co., Inc., Princeton, N. J.)* The Deputy-Director of the Dunn Nutritional Laboratory at Cambridge, England, has brought us up to date, giving us the benefits of the 30 years that he has been actually engaged in research with the vitamin. This is, therefore, a standard book of reference.

Heredo-Retinopathia Congenitalis, by Carl H. Alstrom, M.D. *(Karolinska Institute, Stockholm 60, Sweden.)* The total material investigated includes 105 families of which a brief account is given. In these families, 15 liveborn children died before the age of one year. One died at birth, and one on the sixth day after birth. Of the remaining 13, seven died before the age of six months. They are not included in the genetical statistical calculations which are based on the children who survived the first year of life. Of these children, 175 exhibited blindness or impaired eyesight soon after birth or during the first year of life. No other cases of blindness or decreased vision were found in this sibship. They comprise an additional 303 sibs who as far as was possible to ascertain, in the course of extensive fieldwork, had unimpaired vision.

The Physiology of the Nervous System, by E. G. Walsh and John Marshall. ($9.50, *Longmans, Green and Co., New York 3, N. Y.)* This text on physiology forms an introduction to clinical work since it is based on the functional approach. One third of the book is devoted to tumors and a large section on the causation of new growths is a masterly discussion of an enormous field. The usefulness of the book is enhanced by the historical treatment of the subjects.

Trends in Gerontology, by Nathan W. Shock. ($4.50, 2nd edition, *Stanford University Press, Stanford, Calif.)* Recent developments in this field are described in the completely revised edition of this book. We get a comprehensive view of the various problems of aging. Interest is growing rapidly in this subject and there are many new developments in research and in programs all of which are treated in this volume.

Headache; Diagnosis and Treatment, by Robert E. Ryan, M. D. ($6.75, 2nd edition, *The C. V. Mosby Co., St. Louis 3, Mo.)* Recent advances in methods of diagnosis and treatment of headache make necessary this new edition. Many new aids are now available to help the physician establish a correct diagnosis and many new preparations and procedures have appeared to improve treatment both symptomatically and prophylactically. Hence, this is a book that almost every physician will need for reference.

The Year Book of Medicine, 1957 - 1958 Series, by Paul B. Beeson, M. D., and others. ($7.50, *Year Book Publishers, Inc., Chicago 11, Illinois.)* This series, of course, has become standard in the libraries of a very large number of American physicians. This particular text is up to the standard of the previous editions. There is no better way to review the advances in medicine than to spend the long winter evenings with this text.

Pathological Histology, by Robertson F. Ogilvie, M. D. ($11.00, 5th edition, 334 photomicrographs in color, *Williams and Wilkins Company, Baltimore 2, Md.)* The purpose of this book is to overcome the difficulty and uncertainty inherent in teaching large classes. The students see the sections demonstrated on the screen and then examine their own series under their own microscope and then they have this text as a sort of atlas with which to review and make certain that they understand the changes which are seen in the particular sections.

Illustrated Preoperative and Postoperative Care, by Philip Thorek, M. D. ($5.00, *J. B. Lippincott Co., Philadelphia 5, Pa.)* Emphasizes the need of laboratory tests when indicated, but this can be overdone. Patients are often studied to death. It is indefensible to prepare them for death instead of the operation. These illustrations help to do the right things in emergencies.



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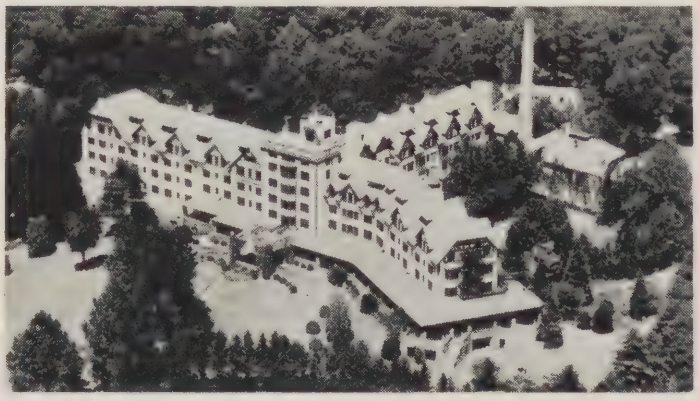
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In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

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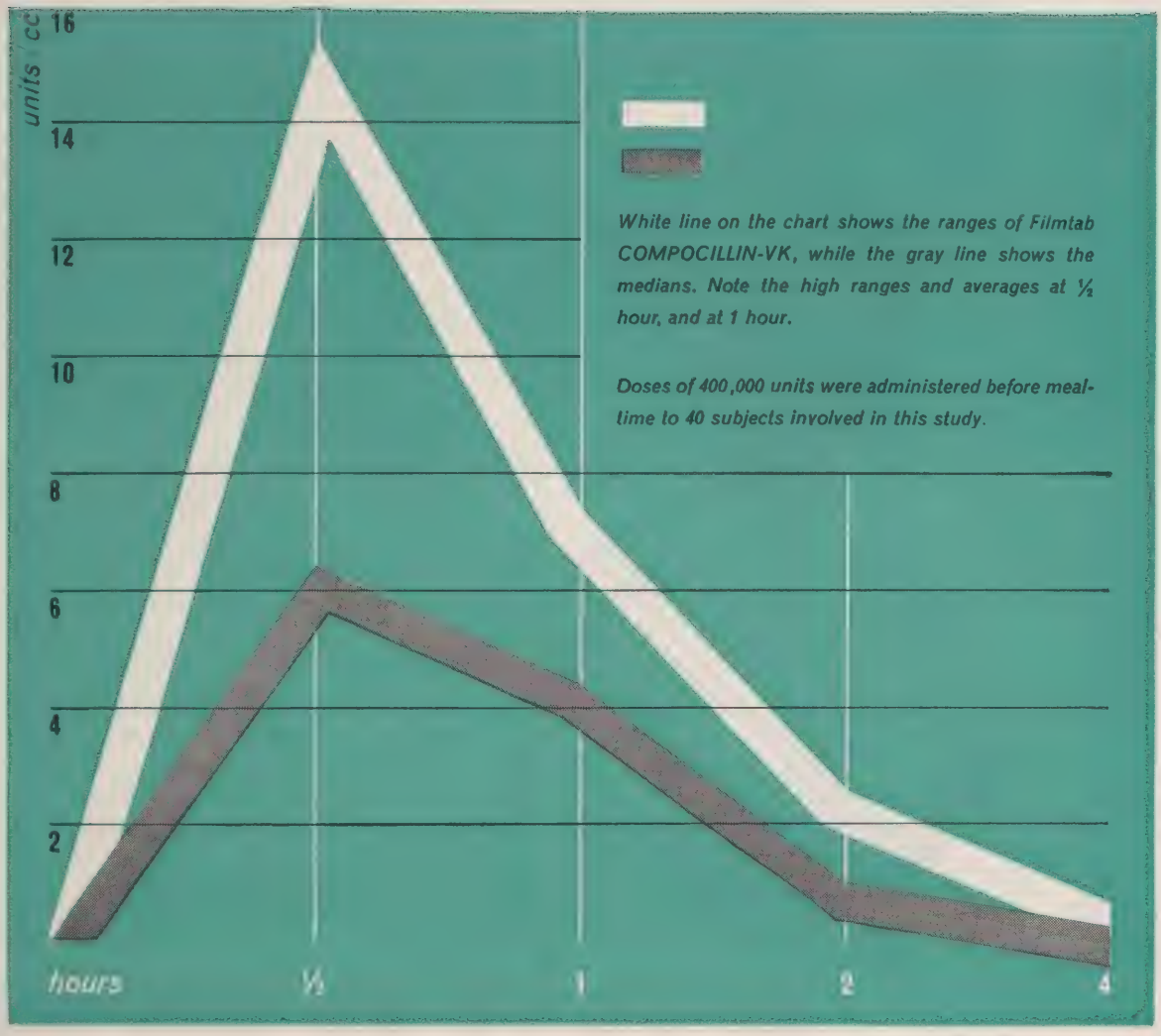
Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

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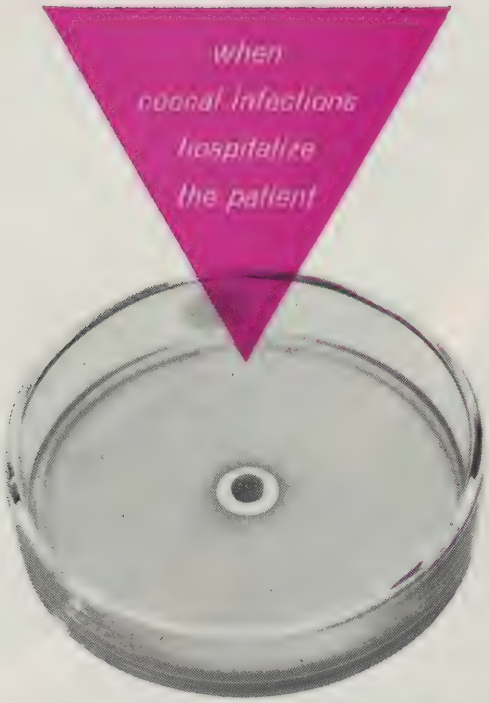
Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

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dosage:

Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight-or 12-hour intervals.

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1. Antibiotics Annual, 1956-'57, p. 706.
2. Antibiotics Annual, 1957-'58, p. 180-7.



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Pyribenzamine® EXPECTORANT breaks up cough

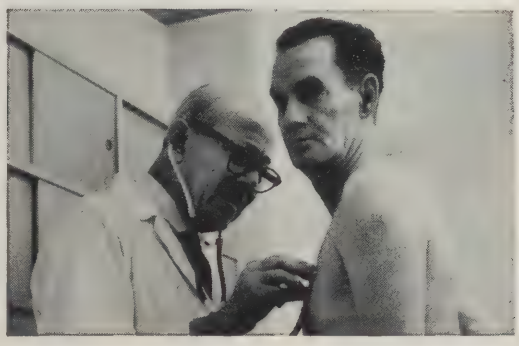
even persistent cough



Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief– a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine*, containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon.

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Clinical "curiosity" rather than clinical "instinct" is the key to accurate diagnosis of gout. Visible manifestations may not appear until late in the course of the disease. Moreover, the patient's description of the pain and the site of the pain may not differ markedly from other articular disorders.

THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

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'Benemid' is firmly established as an *effective* and exceptionally *safe* uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

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Each tablet contains:

Aspirin	200 mg. (3 grains)
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Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:

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Narcotic blank required.

Potentiated Pain Relief

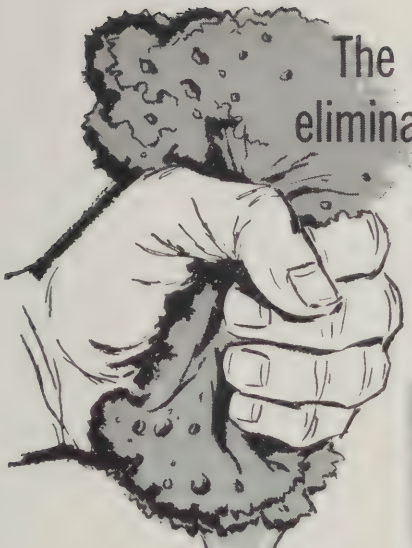
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WITH ADRENAL CORTICOID THERAPY, KAON IS USEFUL IN PREVENTING POTASSIUM DEPLETION.

References: W. J. Kolff, "Acute Renal Failure: Causes and Treatment," The Medical Clinics of North America, *30*:1052 (July 1955).

Peter Forsham, "Symposium on Adrenal Corticoid Therapy," Metabolism, 7:19 (Jan. 1958).

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You and Your Public . . .

Grass Roots Drought May Be Why Medicine's Legislative Crops Fail to Flourish

THE physician's public includes more than just his patients. His public is everybody, particularly in this day when medicine and medical men are of such great interest to the public.

And this "everybody" in the physician's public includes his fellow citizens elected to serve in office. Further, it includes those who see to it that these persons are elected.

It is for this reason that an article in the August 25 issue of *Medical News* is extremely pertinent. It points out that if those elected to office know and understand medicine's views before their election, then many of medicine's last-ditch legislative battles could be avoided.

Ohio physicians do a better job of keeping in contact with legislators than do the physicians in some states. Nevertheless, Ohio doctors can't be smug. They can do a far better job. Also, many more of them should be doing something.

Here's the *Medical News* article in its entirety. Read it. Ponder it. Follow the excellent advice it offers.

* * *

Medical News Says

The 85th Congress saw and heard more medical men than any other Congress in our history.

A seemingly endless procession of physicians paraded up Capitol Hill to appear before various committees considering legislation that would affect the medical profession in one way or another. They've read statements and answered questions on such subjects as increased social security, old age problems, Medicare, the Forand bill, the Jenkins-Keogh bill, VA hospitalization, research facility needs, medical education grants—the list goes on and on.

No Happy Experience

For the majority of doctors who testified at committee and subcommittee hearings, it wasn't a happy experience.

One prominent medical educator, after a particularly harassing session before a House health subcommittee, summed it up wryly: "It would seem that we're not among friends."

It is increasingly apparent that he's right. The question is, why?

Why does organized medicine continually find itself making last-ditch, back-to-the-wall fights to convince noncommittal or unsympathetic legislators that its views on proposed health legislation are valid?

Why are physicians being constantly exhorted —usually at the eleventh hour—to wire their representatives in state house and Congress, in order to make known the honest beliefs they've held for years?

And why, in so many instances, do the last-minute society resolutions, explanations and telegrams fail to accomplish their purpose?

Individual Doctors Blamed for 'Drought'

Dr. Ervin L. Bernhart, new president of the Conference of Presidents and Other Officers of State Medical Associations, has come up with an answer—though it may not, he concedes, be the *whole* answer.

There is, says Dr. Bernhart, a drought in the political grass roots of American medicine. And the blame for it can be laid at the individual doctor's door.

As a past president of the Milwaukee County and Wisconsin State Medical Societies, Dr. Bernhart doesn't absolve himself and other medical leaders.

"We, the presidents and officers of our state medical societies, have simply not laid the facts on the line to our members. . . . We ourselves have become too complacent with the illusion that somebody will do something when the time comes—that resolutions rightly timed will turn the tide; that the legislature or Congress can be persuaded to see things our way by honest and skillful lobbying; that a well-documented, strong appeal at the committee hearing will cause the law-making body to do what it should."

But nothing, he points out, could be further from the truth.

"Medicine is failing to protect itself and the public health by forgetting the first fundamental of grass-roots politics; personal contact."

Speaking to members of the Conference in San Francisco, Dr. Bernhart didn't mince words. "We've done a lot of grass-roots *talking* at medical meetings as far back as I can remember—but for some reason, our talk seems to have been

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nothing but hot air. Without some grass-roots *action,* all of our talking is worthless."

Must Make Facts Known

As one example, he cited constant severe attack on the profession for "increased cost of medical care." Yet, he pointed out, few of the critics have made any effort to distinguish the costs of hospitalization and ancillary services from the cost of doctors' services. "We know the facts," says Dr. Bernhart, "but they won't do us any good unless we can make them known in good time to the legislators."

Most state and national politicians begin their careers in the city council or the county board. That's where they form their first impressions of physicians—and where they *should* first become sympathetic with the problems confronting medicine. Says Dr. Bernhart: They don't. And the reason is that the individual doctors in the community haven't taken the time or trouble to give them accurate information.

How many doctors, he asks, are at this moment active in helping to choose the candidates who will be elected to the next Congress? Or in furnishing medicine's side of the story to those who have already been chosen? The number is pitifully small.

As a result, he concludes glumly, candidates will be elected to office to get favors for the special groups—often smaller than medicine—who have organized to put them there. "Then, after election, the medical profession will be called upon to make a last-ditch effort to prove the validity of its program to legislators already pledged to vote against it."

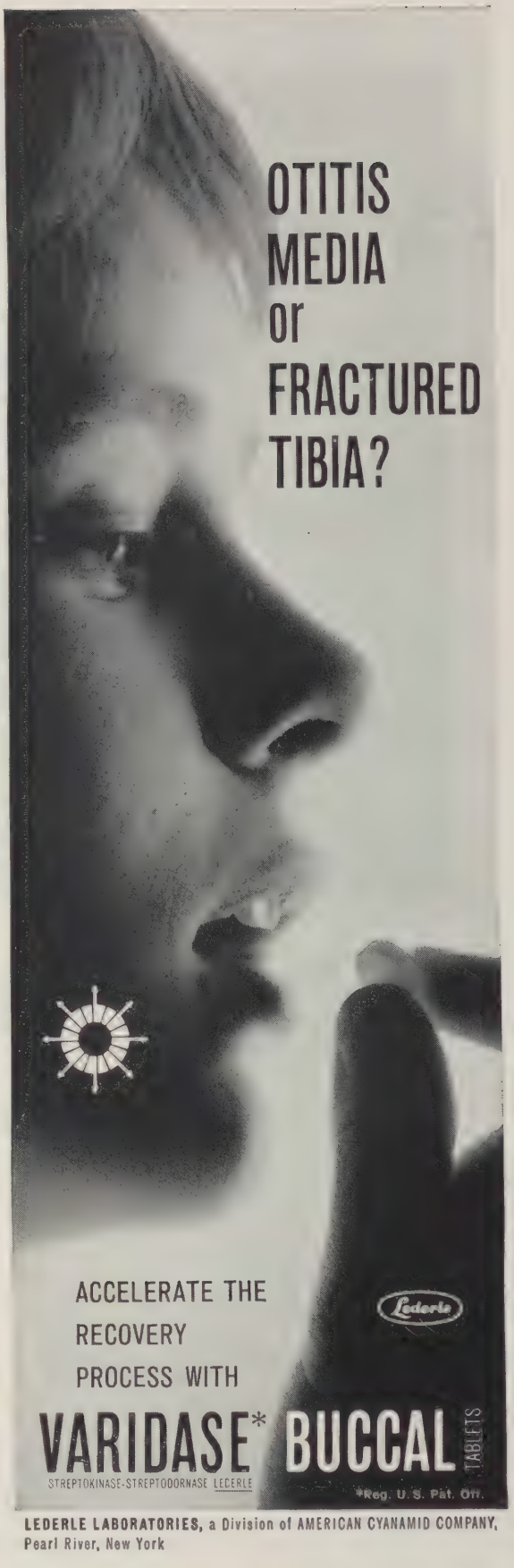
It's up to the individual doctor to fight for organized medicine's opinions at the grass-roots level, to inform, to choose, to elect.

"If we don't," concluded Dr. Bernhart, "we're going to be in the same fix every year from now on."

Growth of Health Professions Shown in New U. S. Report

A newly published Census Bureau report makes some interesting statistical disclosures on the health professions since 1920. While engineers were increasing more than 300 per cent between 1920 and 1950, accountants and auditors more than 200 per cent and social workers by 100 per cent, the number of MD's rose less than 35 per cent. For all professional and technical workers, the increase was approximately 125 per cent.

The increase in dentists was correspondingly small, from 56,152 in 1920 to 75,944 in 1950. Optometrists doubled in number, to 14,916. Pharmacists went from 64,236 ot 90,307; veterinarians' gains were negligible—from 13,494 to 13,679.



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A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*

Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
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Methylparaben	4 mg.
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Bottle of 4 oz.



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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Construction of the National Library of Medicine building is expected to start sometime in the spring of 1959. President Eisenhower readily signed into law the Congressional bill providing $7.3 million for construction and equipment of the building.

* * *

White House Conference on Aging is scheduled to be held sometime in January, 1961. Purpose is to "arrive at facts and recommendations concerning the utilization of skills, experiences and energies and the improvement of the conditions of our older people." Date was set two years in advance to enable state and local governments, the professional and lay persons working in this field to prepare and collect material in line with the purpose of the conference.

* * *

Western Reserve University has been included among 51 teaching, clinical and research institutions that will get a total of $12,789,758 in matching funds to help them build and equip facilities for scientific studies in medical and biological sciences. WRU allocation amounts to $1,253,686.

* * *

With applicants for military commissioning for residency deferment or early active duty lagging far behind 1957 rate, armed forces medical officer procurement program will be compelled to call upon Selective Service to provide doctor-draftees next spring. Since local draft boards prefer to induct residents rather than physicians in private practice, hospitals may be hardest hit.

* * *

On heels of complaint that Federal Trade Commission failed to curb fraudulent advertising for weight-reducing claims, House Government Operations Committee has charged FTC with laxity in cracking down on misleading advertising involving tranquilizer drugs and dentifrices.

* * *

Despite so-called pushbutton warfare "fought from a sitting position," it apparently still takes two feet to make a soldier. August issue of *Military Medicine* contains article pointing out that foot injury and disease is still a big army problem.

World Medical Association, which observed the tenth anniversary of its founding September 18, drew warm praise from Senator John Bricker for its accomplishments in Senate speech.

* * *

New executive director of Medicare is Col. Floyd L. Wergeland, succeeding Maj. Gen. Paul I. Robinson, who became Metropolitan Life Insurance Co. coordinator of medical relations following his recent military retirement.

* * *

Late summer rise in paralytic polio cases climbed well above 1957 rate. Surgeon General said physicians may wish to recommend fourth shot of vaccine for children who had third shot more than a year; American Academy of Pediatrics has recommended fourth shot as well. Biggest job, however, is to get at least three shots into millions under 40 who haven't even had one shot.

* * *

Christ Hospital Institute of Medical Research, Cincinnati, is one of eight institutions awarded Public Health Service contracts for further research in cancer chemotherapy.

* * *

Hospital and institutional construction by private interests showed a sharp gain in the 1958 construction season, some 20 per cent over the 1957 level, according to the Departments of Commerce and Labor.

* * *

AMA's efforts to save post of assistant secretary of defense for health and medical affairs have been successful. Defense Secretary Neil McElroy has notified the incumbent, Dr. Frank S. Berry, that the post will be retained under forthcoming Defense Department reorganization. The decision has the approval of the President.

* * *

Veterans Administrator Sumner G. Whittier has called for explicit law clearly defining requirements for eligibility for VA hospital and medical care. Non-service-connected care is a main issue.

Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

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...from moderate to severe pain complicated by tension, anxiety and restlessness.

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Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

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Codeine Phosphate	gr. ¼
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

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Acetophenetidin	gr. 2½
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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DEFINITION OF EMERGENCY SERVICE WELL WORTHWHILE

The Knox County Medical Society recently completed a project that other medical societies may find worthwhile to follow. The project involved a study of the number and types of emergency cases treated at Mount Vernon's two hospitals.

As a result of the study, Dr. James McLarnan, president of the society, issued a public statement designed to offset some of the unnecessary and impractical demands the public often makes on such services.

Dr. McLarnan explained to the people of Mount Vernon that Knox County Medical Society members provided the service to assure prompt emergency care when the patient cannot contact or has no family physician.

He added, "Emergency treatment has been defined as that given when a life is at stake and must be administered immediately. However, in this community, it has been modified to include treatment which cannot ordinarily be provided in a physician's office.

"As the emergency service is manned entirely by physicians in active practice in Mount Vernon, this service is not intended to provide round-the-clock out-patient care for minor illness or to interfere in any way with a regular doctor-patient relationship. In all cases, except those where life is immediately in danger, a person should consult his regular physician for instructions."

This problem is not limited to Mount Vernon. Other medical societies face it, and they may find that to follow the Knox County Medical Society's action may help to eliminate a time-consuming and costly habit on the part of too many people.

INVESTIGATE BEFORE CHANGING MODE OF PRACTICE

In its recent booklet, "Articles of Association for Unincorporated Associations," the Law Department of the AMA makes this most pertinent statement which should be heeded by those physicians who may be contemplating forming an unincorporated association for tax advantages:

"It must be remembered that the legal and tax involvements of corporations and unincorporated associations are intricate. They should be utilized in group medical practice only if the financial advantages are clearly persuasive and will not interfere with traditional physician-patient relationships, and then only upon the advice of competent legal and tax counsel."

For Ohio physicians, this additional "remember" should be added: Remember, the corporate practice of medicine in Ohio is unlawful and that certain practices by groups, organizations, partnerships, etc., other than corporations, also are unlawful and unethical. The recent statement by The Council of the Ohio State Medical Association, published in the July, 1958, issue of *The Journal,* points up this question in detail.

It would be wise for any physician contemplating a mode of practice which differs from the traditional personal physician-patient relationship to investigate before he changes.

LAWYERS TO BE SURVEYED ON MEDICAL MATTERS

A survey of attorneys on various subjects of mutual interest to physicians and lawyers will be conducted early this fall by the AMA's Law Department. Approximately 10,000 lawyers will be asked to answer questions on interprofessional relations, medical professional liability and expert medical testimony.

The need for such a study is evidenced by the fact that as high as 80 per cent of all cases tried today require medical testimony and that seven out of 10 personal injury cases are decided on medical rather than legal considerations.

The medical profession should be aware of the problems of attorneys and the role of medicine in the judicial system.

Information which the study will reveal can be used to promote good working relations between physicians and attorneys. It is a very worthy project. It is hoped the lawyers surveyed will cooperate.

HOW ABOUT SOME SALES TALK ON PREVENTIVE MEDICINE?

Getting the people to realize the value of good preventive medicine has never been an easy thing to sell. More and more persons today are aware of its value but still there are too many who wait until illness hits before thinking about their physical and mental well-being.

Physicians in their chats with their patients—and others—can do a job of selling preventive medicine, if they will but take the time to do so.

Why do we talk about this? Because of the

following editorial which appeared in the official bulletin of the Columbus City Health Department recently:

"Probably because we have so little of it in comparison with how much we'd like to have, the American people dislike to spend their money unless there's a definite need. Probably that's why those who disburse insurance are salesmen, rather than solicitors. And as we all know, creating the desire for a product is the foundation of successful advertising.

"That is why the average American family will wait until somebody is actually sick before they'll spend money with a doctor. We all have a desire to keep well people well, but we have to be exposed to salesmanship of one kind or another before we see the economy of spending our hard-earned dollars to protect our health.

"In the last few years, however, many farseeing folks are realizing the advantages of protective health practices. It's cheaper in dollars and cents and to a considerable degree it eliminates pain, illness, and unemployment.

"The program need not be elaborate. In fact, the simpler the better. One facet is a complete family record, kept in handy location, of all inoculations and physical and dental check-ups. Another is an understanding that pre-ailment attentions are an investment in good health. A third is a determination to follow a pre-arranged schedule any physician will be glad to assist in preparing.

"Immediate results may not be apparent, but over the years they will compose a firm argument in favor of preventive practices that easily could amount to the price of a new car or a substantial down payment on a home. Besides, regular visits to a physician or dentist when a child is obviously well tend to reduce his anxiety in future visits, whether he is confronted either with a routine or an emergency situation.

"A fitting slogan for such a program might be something like 'see your doctor when you're well and only see him once. If you wait until you're ill you'll be going back for months.' "

HOW ARE FOREIGN GRADUATES BEING SCREENED?

Asks a member:

What's being done to screen the foreign medical graduates who want to practice in the United States or prepared themselves for practice in this country?

Information from the AMA on this is as follows:

The Educational Council for Foreign Medical Graduates is sponsored by the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Federation of State Medical Boards of the United States. Its primary functions are, first, to provide information to foreign medical graduates wishing to come to the United States; second, to provide a means of assuring, before they come to this country, that foreign medical graduates seeking internships or residencies in American hospitals have the medical training and knowledge and the necessary command of English to serve effectively in those capacities.

Inquiries from almost 400 foreign medical graduates have been answered with letters and published materials since the ECFMG opened its office on Oct 1, 1957. The American Medical Qualification Examinations are of the multiple-response, objective type given in a single day with 200 questions in the morning and 200 in the afternoon. Included in the examination will be questions on medicine, surgery, pediatrics, obstetrics and gynecology, anatomy, physiology, biochemistry, microbiology, pharmacology, and pathology.

Passing of the three-way screening of credentials, of command of English, and of knowledge of medicine will gain for the foreign medical graduate the recommendation of the ECFMG's four sponsoring agencies that he be considered by hospitals, licensing boards, and specialty boards on the same basis as are graduates of American medical colleges.

NOTHING TO FEAR IF YOU'RE RIGHT

Unfortunately, some physicians do not understand, or have a misconception of, the reasons for a local society grievance committee and how it functions.

To put it bluntly, the grievance committee, by trying to mediate differences between a physician and a patient, undertakes a job which should be taken on by the physician himself. Obviously, this can't always be done because of personalities, unreasonableness, on both sides, or some other not too important reason.

The physician who has dealt fairly and competently with his patient has nothing to fear from a grievance committee. He should keep in mind that statistics reveal that the overwhelming number of grievances are due to misunderstandings—misunderstandings which could have been dispelled quickly had frank discussion been possible and actually undertaken.

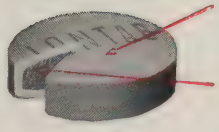
Because so many cases referred to a grievance committee are settled in a manner satisfactory to both patient and physician, the physician should be glad that a mechanism of this kind has been established. Without it, many misunderstandings

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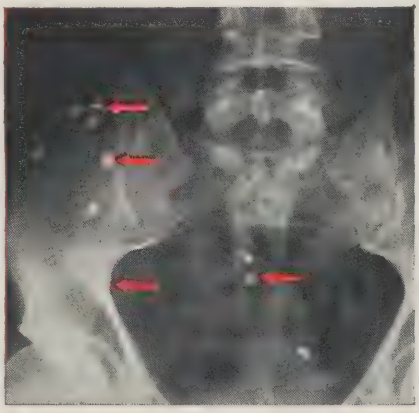
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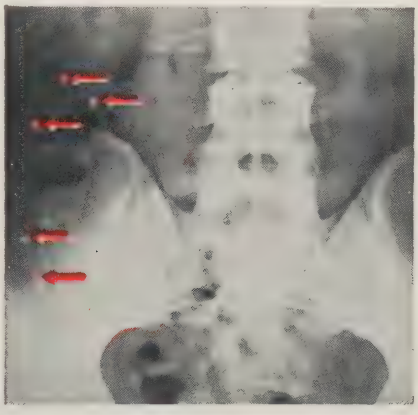
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would never be clarified, resulting in the compounding of bitterness on the part of the patient and often the spreading of unfounded detrimental charges concerning the physician.

CIVIC ENTERPRISES AND MEDICAL ETHICS

How would you answer this question: May a physician permit his name to be used in connection with civic enterprises (e. g., subscription to building funds, season concert series, community fund activities, etc.)?

Here's the way the Judicial Council of the AMA answered it:

"The Judicial Council, at a recent meeting, approved the following comments expressed by Dr. George F. Lull, Secretary of the Association, in answer to a request similar to the above:

" 'I believe it is an excellent thing for physicians to take part in civic enterprises. I think we have gone the other way and held ourselves aloof so long that we are not considered part of the community in many places. It is my personal opinion that our public relations can be improved by each individual physician's activities, since the people who come in contact with him usually judge all physicians by his standards.'

"The Judicial Council does not believe that the use of a physician's name in connection with a civic project should, in itself, be considered contrary to the Principles of Medical Ethics."

DO THE SPORTS EVENTS IN YOUR AREA HAVE PROPER MEDICAL SUPERVISION?

Interscholastic athletics are about to reach their seasonal peak in all corners of Ohio. Therefore, it would be timely for all County Medical Societies to take a direct interest in what goes on in their communities.

In other words are the interscholastic sports activities—the intramural programs, for that matter— in county under proper medical supervision? If not, why? Has the medical profession indicated a willingness to cooperate with the school authorities on this? Have the school authorities asked for and welcomed the help of the medical profession?

These are questions which should be asked and answered in each Ohio community. They imply big responsibilities on both the medical and teaching professions.

The Committee on Injury in Sports of the American Medical Association states that the athlete has the right to expect good health and medical supervision.

The committee has explained what it means by good medical care in the following language:

"Good medical care includes, first, a thorough preseason history and physical examination. Many of the sports tragedies which occur each year are due to unrecognized health problems. Medical contraindications to participation in contact sports must be respected.

"Second, a physician present at all contests and readily available during practice sessions. It is unfair to leave decisions to a trainer or coach as to whether an athlete should return to play or be removed from the game following injury. In serious injuries the availability of a physician may make the difference in preventing disability or even death.

"Third, medical control of the health aspects of athletics. In medical matters, the physician's authority should be absolute and unquestioned. Today's coaches and trainers are happy to leave medical decisions to the medical profession. They also assist in interpreting this principle to students and the public."

LOCAL AREAS MUST SOLVE POOR RELIEF PROBLEM

In quite a number of counties, officials are having trouble in carrying on an adequate poor relief program. The medical parts of such programs are being drastically cut—medical fees reduced, ceilings put on hospital payments, authorizations reduced to a minimum.

The solution lies in digging up more funds, primarily from local general funds or through local special levies.

Poor relief is financed from four sources: a 1 per cent public utilities excise tax; a .65 per cent public utilities excise tax; a legislative appropriation from the state General Revenue Fund, and, in some communities, locally-raised funds appropriated by local governments. Few cities or counties have been using locally-raised funds so long as their share of the excise taxes, plus state "matching," is sufficient to meet obligations.

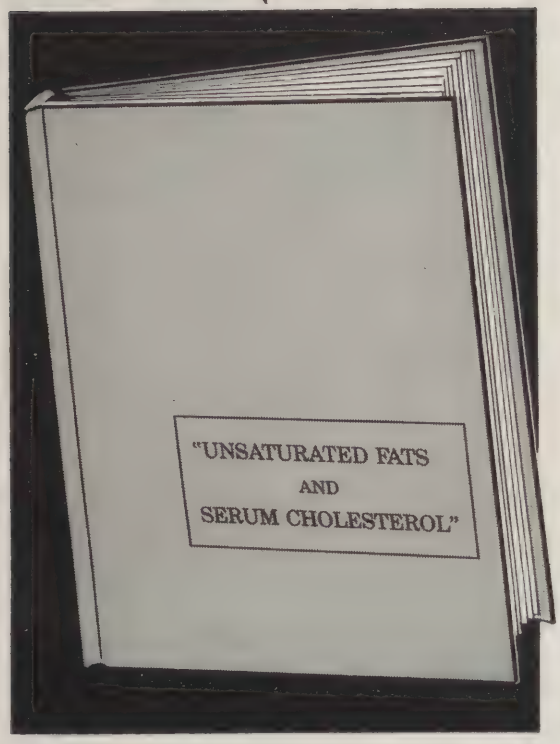
The local areas are reaping the whirlwind. In good times, the money from the state was adequate or almost adequate for poor relief. So, little if any money from local general funds had to be used. The people didn't have to dig into their jeans for poor relief money—the state paid the bills. Now it's different. Relief rolls have increased. There has been no increase in state money.

It's high time that local areas put their houses in order on this matter of financing poor relief. In the end, the people in each community have some obligation and must assume some responsibility for problems which are local in scope.

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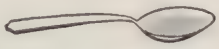
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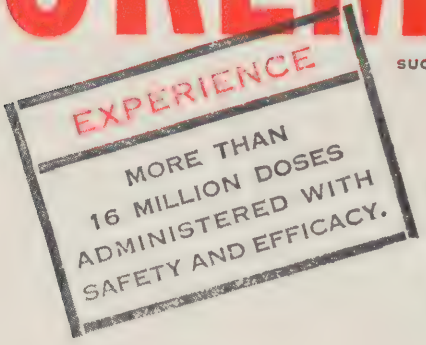
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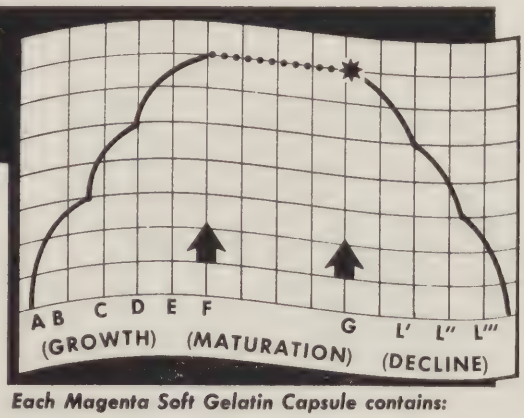
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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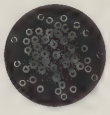
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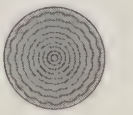
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70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Age 65 Is Not Retirement Age for Many Workers, Study Shows

Large numbers of people in our country continue in gainful employment beyond their 65th birthday, it is reported by statisticians of the Metropolitan Life Insurance Company.

According to estimates by the Bureau of the Census, in March of last year more than half of the male population in the age group 65-69 was still in the labor force; even at ages 70-74, the proportion was practically two fifths, but at ages 75 and over it was only one sixth. The proportion of women in the labor force at the older ages is much lower.

Farm workers show a greater tendency to work beyond age 65 than do those in non-agricultural industries. Consequently, men and women gainfully employed on farms constitute an increasingly large segment of the working population at these ages. While only one tenth of males in the age range 14-64 are engaged in agriculture, the proportion is nearly one fourth at ages 65-69 and almost one third at ages 70 and over.

The majority of older employed persons work full time, the proportion of full-time workers being two thirds for the men and more than half for the women.

"Older workers drop out of the labor force for various reasons," the statisticians conclude. "Many retire voluntarily or because they have reached mandatory retirement age. Pension plans, Social Security, and life insurance benefits have made it possible for an increasing number of people to retire. Since the incidence of disabling disease rises rapidly with advance in age during later life, failing health and physical disabilities are among the major reasons for older workers leaving the labor force."

Ask AMA Help on Nursing School Accreditation

The American Hospital Association House of Delegates has adopted a resolution which would explore the possibility of establishing an independent joint commission on accreditation of hospital schools of nursing. The resolution as adopted said:

"To request the National League for Nursing and the American Medical Association to join the American Hospital Association in establishing as rapidly as feasible an independent joint commission on accreditation of hospital schools of nursing, to be composed of these and possibly other groups, in order to spread the responsibility and financing for the accreditation program more fairly among those who benefit from the services of graduates of hospital schools of nursing."



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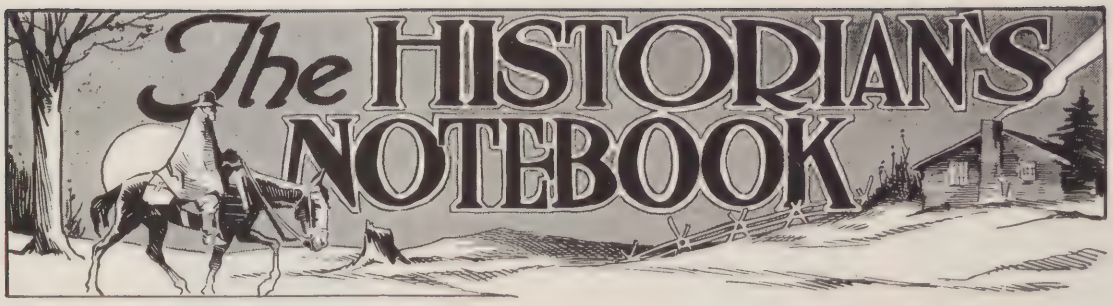
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70 YEARS OF SERVICE TO THE MEDICAL PROFESSION



Dr. Mary Edwards Walker (1832-1919); Charlatan or Martyr?

LINDEN F. EDWARDS, Ph. D.

PART II

(Concluded from September Issue)

ALTHOUGH Dr. Walker spent most of her postbellum life on L Street N.W., near the corner of Tenth, in Washington as a registered practitioner of medicine she never established a practice as extensive as she enjoyed at Rome, New York. In September 1866 she sailed for Europe where for a year she visited hospitals and gave lectures to large audiences in London, Manchester, Glasgow and Paris on her favorite topics of dress reform, woman suffrage, capital punishment, the evils of strong drink, the tobacco vice, and the prevention of infanticide. Inasmuch as she was said to be only a mediocre speaker it is likely that the main attraction to her lectures was her garb, the American reform dress as she called it, which on these occasions usually resembled a full dress suit, including a high hat and cane and white gloves. While on this lecture tour she once lectured to a full house in the great St. James Hall in London and was presented to Queen Victoria.

After her return to this country she continued to give lectures, published an occasional article in magazines and wrote two books, one entitled *Hit,* published in 1871 and the other entitled *Unmasked or the Science of Immortality,* published in 1878. For a time she held a clerkship in the Department of Interior and was once appointed to a clerkship in the Treasury Department but her appointment was never confirmed because of objections raised by other women in the department on account of her mode of attire. She received a slight army pension which supplemented her income from medical practice and lectures and in 1890 she inherited the family farm at Oswego, New York, which she managed for a time. At the homestead she conducted for a short time a sanitarium for consumptives and a school for the prevention of this disease on plans which she originated but finances prevented her from carrying through her project.

Throughout her entire career she devoted her life to the cause of woman's rights and the emancipation of her sex, although she was usually not in sympathy with her contemporary woman's suffrage proponents and she in turn was not popular with them.

Her Career in the Nation's Capital

Dr. Walker was a familiar figure at the Capitol building in Washington where she spent a great deal of her time lobbying for bills in behalf of her sex and for other reforms. During the 1870's she abandoned her Reform Dress and adopted full masculine apparel consisting of striped trousers, a stiff-bosomed white shirt, frock coat and a high silk hat but with long curly hair. Her one concession to femininity was her long curls, which she claimed she wore so that everybody would

The Author

● **Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.**

A paper read at the meeting of the American Association for the History of Medicine, Williamsburg, Virginia, May 8, 1957.

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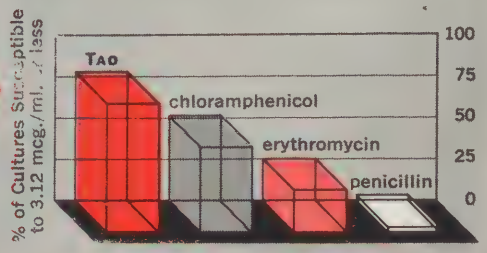
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REACTIONS:

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References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

know she was a woman. However, she betrayed her feminine vanity on one occasion when, according to the account, she had her picture taken laid out as if dead with her clothing fastidiously arranged and flowers scattered about because she wanted to know how she would look when she passed away.

The story goes that whenever a new guard was employed at the Capitol he was informed not to show concern when he saw what looked like a little old gentleman with long hair skipping out of the Ladies' Room, since it would be "Dr. Mary," as she came to be known. Her insistence upon her constitutional right to wear men's clothing made her the butt of many jokes, exposed her to many indignities, including arrests, and greatly overshadowed her career as a physician and champion of woman's rights.

It must be admitted that she was an opportunist, as evident by her eagerness to join the Woman's National Dress Reform and Suffrage movements, which, of course were not original with her, being phases of the great era of reform that set in about the middle of the 19th Century. One wonders if her decision to visit Europe was not arrived at because of her desire to emulate Dr. Elizabeth Blackwell who had previously toured the British Isles and France.

Her battles with what she called the evils of nicotine and intemperance are other examples of her eagerness to climb aboard the bandwagon of reform. That she succeeded in attracting attention by her efforts is shown in the illustrated weeklies which delighted in depicting her dressed like a man and in the act of knocking a cigar from the mouth of an amazed male by means of a rolled-up umbrella she carried for that purpose. She claimed that Col. Chester Allen Arthur, later the President, twice proposed marriage to her but that she declined because he used tobacco.

It is said that her army career and her rich experiences abroad, during which she received much publicity and attention, turned her head and aroused her egocentric tendencies. She evidently lacked diplomacy and was quite outspoken. She criticized Susan B. Anthony and other popular leaders of the American Woman Suffrage organization, as a result of which that organization ignored her for many years, and at one time, it is said, she was even barred from the convention hall because of her attack on these leaders. In spite of her lineal qualifications she was unsuccessful until 1913 in becoming a member of the Daughters of the American Revolution.

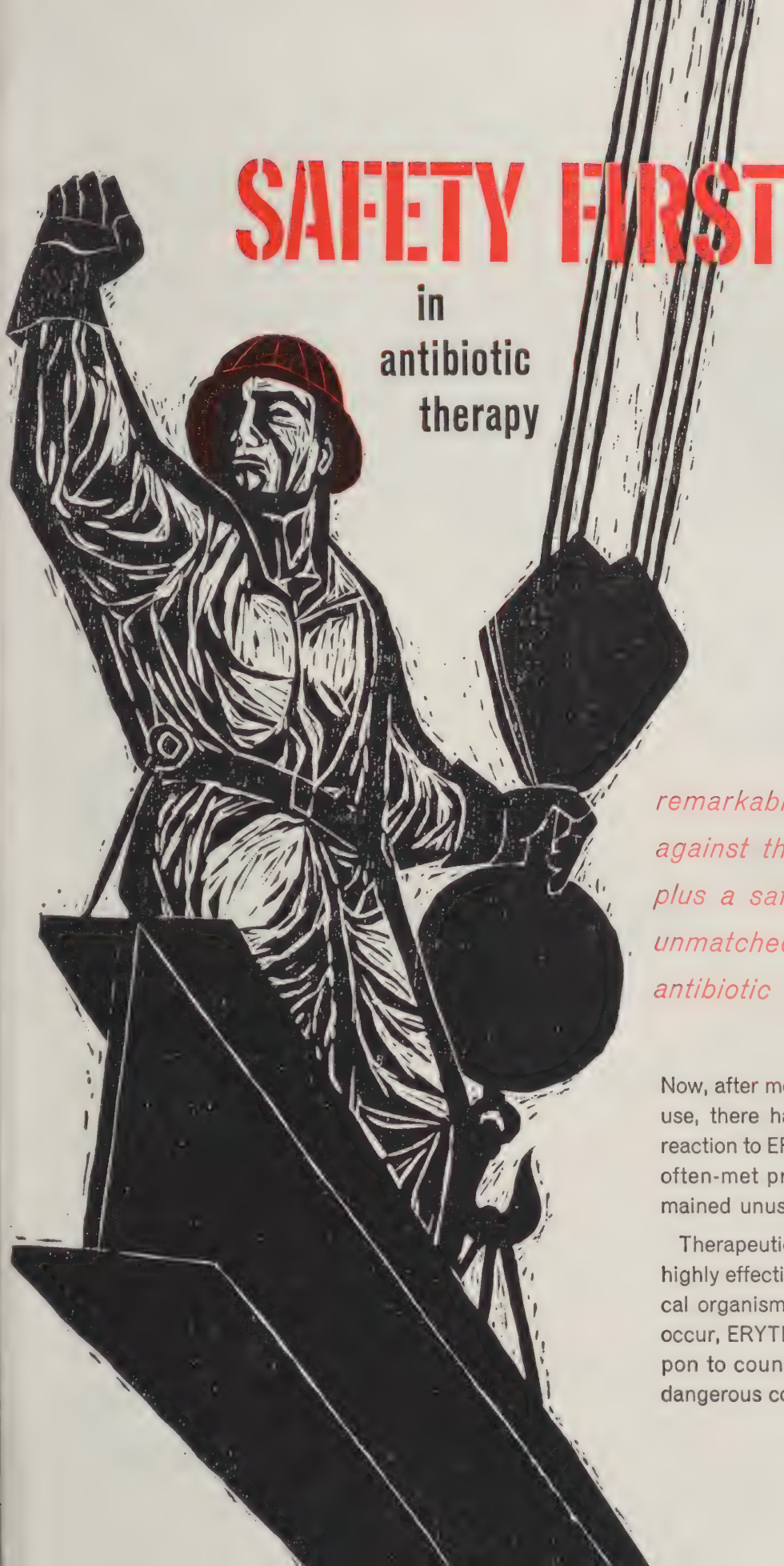
Notwithstanding her eccentricities and strong determination of character, she was nevertheless sympathetic and understanding. It is claimed, for example, that she once sheared her curls and sold them to aid a woman who was financially in need and that once after having a man arrested for jeering at her, moved by pity, she paid his fine. While in Washington donating her services toward the war effort during the 1860's she founded a Woman's Relief Organization, the object of which was to befriend women who came to that city to visit their soldier relative or sweetheart and had no place to stay. She once told about working far into the night helping to write transportation orders on furloughs of New York soldiers to enable them to return home to vote in an election. During her career as a general practitioner at Rome, N. Y., she exerted her efforts for the establishment of a Foundling Hospital in New York City where unmarried women could have their babies and during the 1890's she founded a woman's colony called "Adamless Eden."

Her Impoverishment and Death

According to one of her admiring biographers, Dr. Walker's really worth-while claims to a notable place in history have been mostly ignored and that "the amount of good done by this little woman will never be known, most of it was unrecorded except in the hearts and minds of those she helped." It is sad to relate that eventually Dr. Walker became impoverished, due to her declining income from medical practice, and her small government pension which did not keep her from faring badly. She unsuccessfully besought Congress to award her an additional $2,000.00 for services rendered during the Civil War and finally she had to resort to appearing in dime museums for her livelihood.

Present-day accounts of her career continue to be published occasionally in newspapers, magazines and journals. One of the striking features revealed in reading these sketches chronologically is the growing tendency of writers to be less critical of Dr. Walker's whims and more charitable in depicting her life-long struggle for the emancipation of her sex. That her efforts in this struggle were not in vain are evident at every voting booth in this country, at every factory where women are employed and on every street corner where women attired in slacks, Levi's and Bermuda shorts are common sights.

Although little reliable information is extant concerning Dr. Walker's success as a medical practitioner, reportedly she was as skilled as her male contemporaries in amputating limbs, suturing incisions and alleviating suffering. Her death occurred at the age of 87 in Oswego, N. Y., on Feb. 21, 1919, as a result indirectly of a fall on the Capitol steps in 1917.



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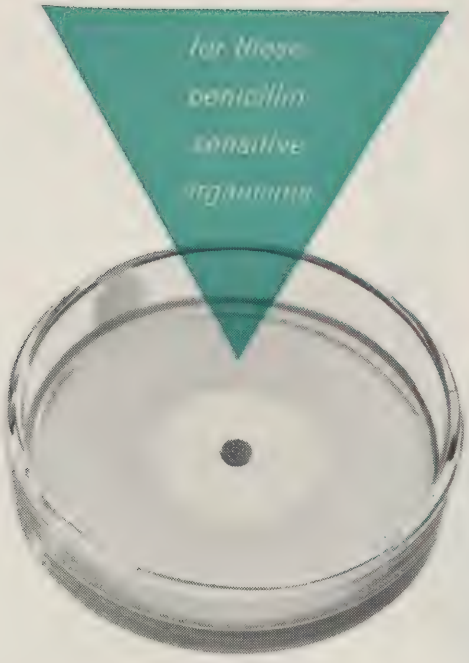
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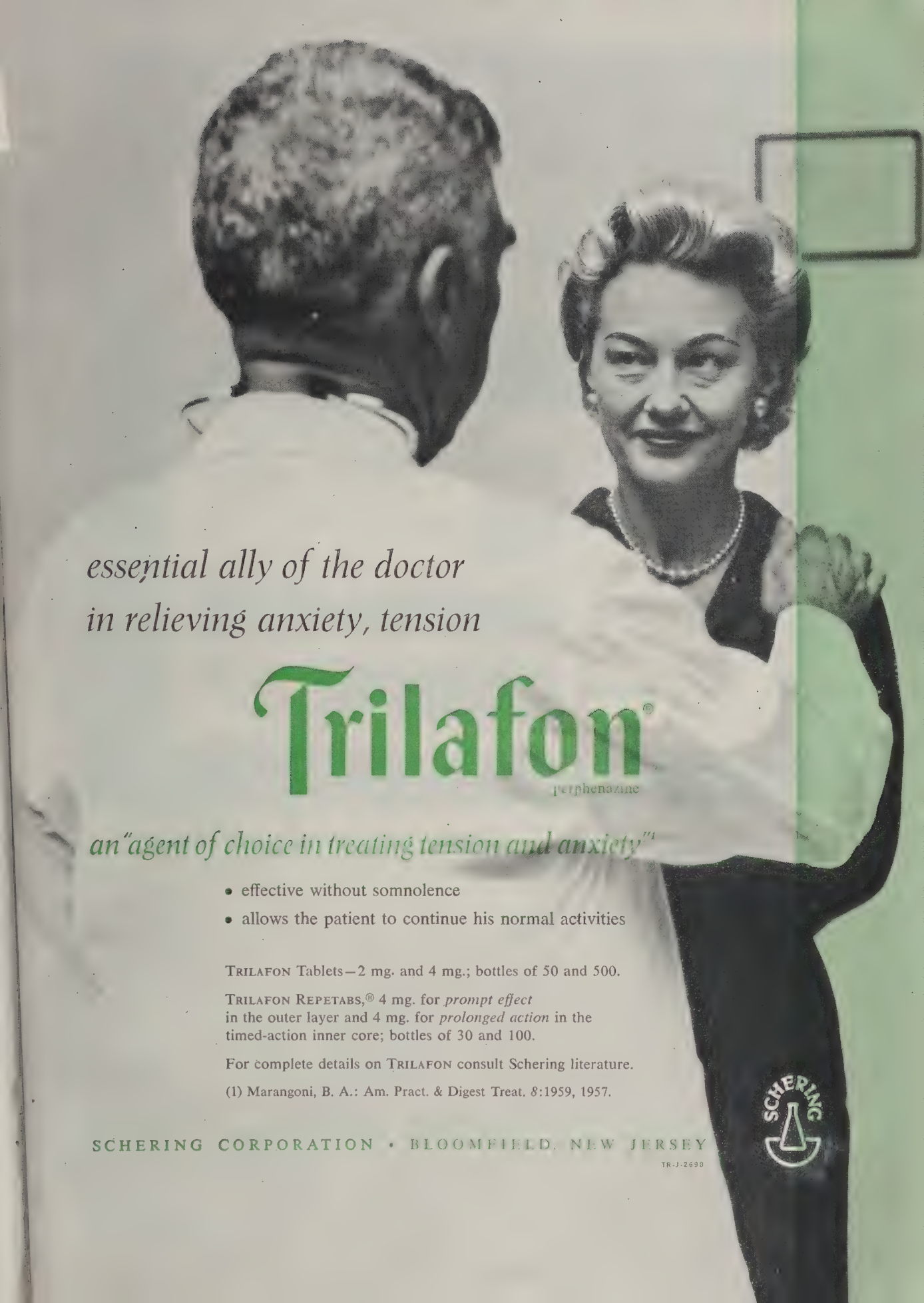
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(1) Marangoni, B. A.: Am. Pract. & Digest Treat. *8*:1959, 1957.

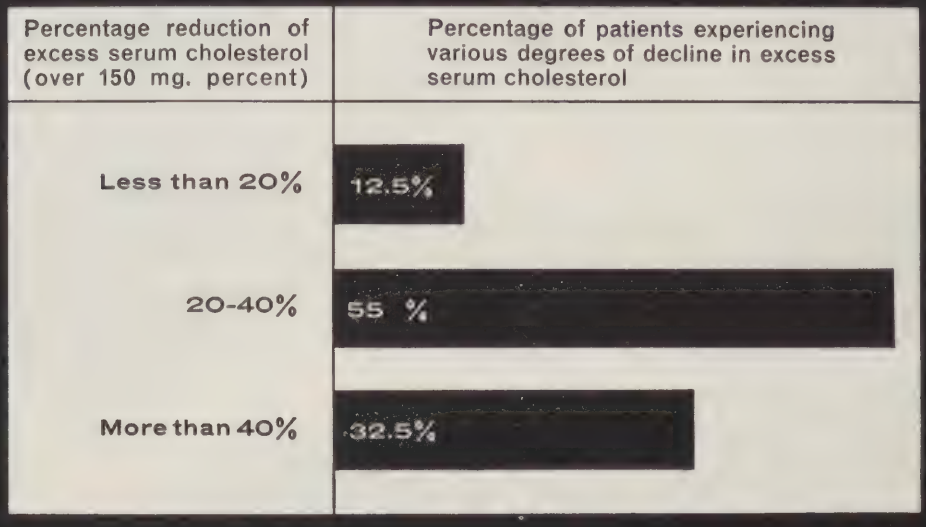
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Vol. 54 October, 1958 No. 10

JONATHAN FORMAN, M. D., *Editor*

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An Evaluation of the Franklin County Cancer Survey Project*

ZEPH J. R. HOLLENBECK, M. D., and JOHN C. ULLERY, M. D.

CLINICAL experience and research in therapy of cancer of the female genitalia have given us a tremendous store of knowledge in methods of application of the various forms of treatment. And yet, when we consider all cases of the most common cancer of the female genitalia —cancer of the cervix—more than 60 per cent of them do not live five years. It is a universally known fact that the earlier in the disease that adequate therapy is carried out, the better are the results.

It is our belief that every woman should have a pelvic examination and a vaginal cytology study at least once every year. I think that the results of the survey presented here will substantiate an even stronger conviction in this belief. This county-wide survey project, using the Papanicolaou smear as a screen test, has been in operation in Columbus (and Franklin County), Ohio, for the past two years. This has been a cooperative study by the Department of Obstetrics and Gynecology and the Department of Pathology of The Ohio State University and under the sponsorship of the National Institutes of Health, Bethesda, Md.

A similar survey has been in progress in Memphis, Tennessee, for the past four years and in other cities for varying lengths of time. In the report of Erickson[1] of the Memphis study, the first 70,000 examinations revealed 527 carcinomas or an incidence of 0.75 per cent (1 in 143). In the Columbus survey, we have found 205 carcinomas in 59,712 examinations or an incidence of 0.34 per cent (1 in 290).

Cancer of the female genital tract seems more prevalent in Memphis than in Columbus. The possible reasons for this will not be discussed here, but it is a startling fact that in Columbus, Ohio, one in every 290 women examined had a cancer of the internal genital tract.

The material studied has come from three sources. There have been 90,786 specimens received of which 66,392 (73 per cent) have come from the offices of private physicians, 8,108 (9 per cent) from the cancer survey project clinic, and 16,286 (27 per cent) from other clinics.

Method of Procedure

The method of making the test is simple and painless. The material from the posterior vaginal fornix is removed with an aspirator and placed on a glass slide. This is covered with another slide,

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- **Dr. Hollenbeck, Columbus, is Professor of Obstetrics and Gynecology, The Ohio State University College of Medicine, and Chief of Staff, St. Ann's Hospital for Women.**
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*From the Department of Obstetrics and Gynecology and the Department of Pathology, The Ohio State University. Presented before the Section on Obstetrics and Gynecology at the Annual Meeting of the Ohio State Medical Association, April 15, 1958, Cincinnati, Ohio.

and the two are slid apart. The second specimen is prepared after the vaginal speculum is in place by scraping the area around and in the external os of the cervix with a tongue depressor or a wooden scraper designed for this purpose. The material obtained is placed on the slide, and the slides are fixed and transported to the laboratory in a mixture of equal parts of 95 per cent alcohol and ether.

In the Columbus study the "aspiration only" method is being used with a control run by a designated few physicians who are using both the aspiration and scrape. Of the 90,786 specimens approximately 13,150 were aspirations and scrapes; the remainder were made by aspiration only. Eighteen (18) patients with cancer were found on positive scrape smears that were negative on aspiration. This certainly emphasizes the value of the scraping test and substantiates Cuyler's[2] work.

In applying this test in your own practice, your cytologist may report his findings in one of three ways: by class, by cytology or by interpretation.

Classification of Papanicolaou Smears

Class	Cytology	Interpretation
I	Normal	Negative
II	Atypical, No Evidence Malignancy	Negative
III	Suspicious, Suggestive-Not Conclusive	Suspicious (Positive)
IV	Strongly Suggestive	Positive
V	Conclusive of Malignancy	Positive

The suspicious or positive smear demands an adequate biopsy of the cervix, preferably by cold knife conization, a dilatation and curettage and an adequate pelvic examination under anesthesia. It must be emphasized here that this test is not infallible, and a negative report in the face of symptoms or positive, clinical findings means absolutely nothing. A patient presenting a suggestive history or suspicious or presumptive findings must have adequate biopsy and examination, regardless of the outcome of the smear. This sequence of events, symptoms with negative smear, usually occurs in endometrial cancer, and this fact has been frequently overlooked.

We must also remember that a positive smear is by no means an indication for therapy. Definitive cancer treatment must be initiated only as a result of a positive biopsy.

In two years, from May 1, 1956 to May 1, 1958, there were 205 cancers of the female genital tract found in our survey of 57,712 women. The various types of carcinomas found are as follows:

May 1, 1956 to May 1, 1958

Carcinoma in situ of the cervix	81
Carcinoma of the cervix	94
Carcinoma of the endometrium	26
Carcinoma of the vagina	3
Carcinoma of the ovary	1
Total	205

Management and Therapy

One of the valuable results of this survey has been the revelation of the various types of management and therapy to which these 205 patients have been subjected. It is of spcial interest to note that there could be no delay, in the institution of therapy, attributed to physician or patient except in three instances of carcinoma in situ of the cervix which were lost to follow-up by patients moving away from the county.

The reader will disagree with some of the methods of therapy as have those of us who have conducted this survey. Definitely, some of the methods are not acceptable and even contraindicated. The majority of the patients have been treated by their own physicians in various Columbus hospitals, and a lack of standard and/or conventionally accepted therapy is evident.

The following tables list the treatment of the 205 cancer patients:

Treatment — Carcinoma in Situ of the Cervix

Total hysterectomy	54
Amputation or cervicectomy	8
Conization	6
Biopsy—cold knife	6
Cobalt 60 and total hysterectomy	1
Cauterization	1
Wertheim hysterectomy	1
Observation (pregnant)	1
None (lost)	3
Total	81

Treatment — Carcinoma of the Cervix Stage I

Cobalt 60 and x-ray	17
Radium and x-ray	8
Radium	19
Cobalt 60 and Wertheim hysterectomy	13
Wertheim hysterectomy	8

X-ray	2
Cervicectomy	2
Total hysterectomy	7
Trachelectomy and x-ray	1
Total	77

Treatment — Carcinoma of the Cervix Stage II

Cobalt 60 and x-ray	8
Radium and x-ray	2
Total	10

Treatment — Carcinoma of the Cervix Stage III

Cobalt 60 and x-ray	2
Radium and x-ray	3
Total hysterectomy	1
Total	6

Treatment — Carcinoma of the Cervix Stage IV

No treatment	1

Treatment — Carcinoma of the Endometrium

Cobalt 60 and total hysterectomy	12
Radium and total hysterectomy	3
Total hysterectomy	10
Wertheim hysterectomy	1
Total	26

(In all but three cases of total hysterectomy, bilateral salpingo-oophorectomy was known to have been done.)

Treatment — Carcinoma of the Vagina

Wertheim hysterectomy and vaginectomy	1
Radioactive gold seeds	1
X-ray	1
Total	3

Treatment — Carcinoma of the Ovary

Exploratory laparotomy and radioactive colloidal gold	1

Two cervical stump cancers were found within a year after subtotal hysterectomy had been performed elsewhere for uterine fibromyomata. There seems little doubt that these patients had their carcinomas at the time of the initial surgery. No biopsy of the cervix or curettage had been performed at the time or prior to the time of hysterectomy.

Importance of Early Diagnosis

Most of the tumors found in this survey were clinically unsuspected (clinically suspected 42 or 20 per cent), but to appreciate the full and tremendous value of the routine Papanicolaou test in detecting 175 cancers of the cervix (of a total of 205 carcinomas), it is well to remember again the International Clinical Classification of Cancer of the Cervix. Stage 0, microscopically no invasion (intra-epithelial); stage I, limited clinically to the cervix: stage II, extending beyond the cervix but not to the lateral pelvic wall (may also involve the upper one third of the vagina): stage III, extending laterally to the pelvic wall (or extending below the upper one third of the vagina): stage IV, with distant metastasis (or a frozen pelvis or bowel or bladder fistulization due to tumor).

The 175 cervical cancers found by this survey were classified clinically as follows:

Stage 0	81
Stage I	77
Stage II	10
Stage III	6
Stage IV	1
Total	175

To further appreciate the value of the Papanicolaou smear we must look at our present results of therapy. These statistics from the Department of Obstetrics and Gynecology of the Ohio State University compare favorably with nationwide and world-wide publications of survival rates.

Five Year Survival

Stage 0	96.2%
Stage I	81.4%
Stage II	48.5%
Stage III	21.4%
Stage IV	2.5%

With these survivals of the various clinical stages of cervical cancer in mind, let us now compare the difference between the registrations in the Tumor Clinic at the Ohio State University Hospital 10 years ago with the cases found by means of a mass survey during the year just past.

1947	Stage	1957
0%	0	38%
14%	I	48%
41%	II	5%
41%	III	7%
4%	IV	2%

To portray this graphically, the incidence of carcinoma in situ of the cervix is noted in figure 1.

The number of cases of stage 0 cervical carcinoma during the years 1947 to 1956 follows generally the increase in the total number of cervical carcinoma cases registered. The time of the institution of the cancer survey project is indicated by the arrow (1956). The 325 per cent increase in the detection of this early and easily curable lesion is almost fantastic. As is evident, earlier lesions *are* being found by cytologic examination.

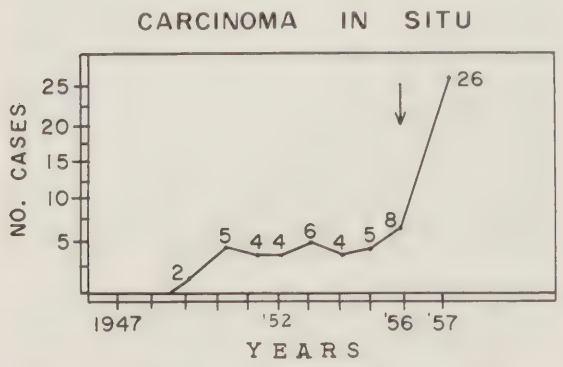


FIG. 1. Carcinoma in situ of the cervix. Registered in University Hospital, 1947 to 1957.

Summary

The objectives of this study and the important conclusions to be drawn from such a mass survey are set forth in previous communications.[3,4] There are some which bear repetition here.

The aspiration and scraping techniques are suitable for large-scale screening. The scraping method will divulge invasive tumors of the cervix as well as in situ cancer that may be missed by aspiration alone. Both should be used. Neither is diagnostic but merely point the way for further tissue diagnosis by biopsy.

Once the diagnosis is made, no delay may be tolerated in the establishment of adequate and complete therapy. This study emphasizes the lack of uniformity in the application of standard methods of treatment of pelvic malignancy. This is particularly true in cancer of the cervix.

Cervical carcinoma has three clinical characteristics that are extremely important in appreciating the value of the Papanicolaou smear test. First, it is, by far, the most common cancer of the female genital tract. Second, relatively good results are obtained if adequate treatment is instituted early. Third, with this method it can be detected earlier than other carcinomas of the female genitalia.

This test can be applied to the practice of anyone who treats women. Let us help in the reduction of the present-day 60 per cent mortality from cancer of the cervix.

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Underlying Psychological Problems Often the Cause of Dyspareunia

Dyspareunia can often be prevented. Shortly after it occurs, it can be alleviated by relatively simple measures. When it is of long standing, it may tax the ingenuity and patience of the physician. When it follows episiotomy or pelvic repair, it may be embarrassing to the physician who performed the operation. When the condition does not respond to the measures herein outlined, the doctor should suspect underlying psychological problems.

Some women utilize even minor vaginal irritations as an excuse to evade their marital obligation. I recall an old maid who married a successful small businessman in order to quit her disliked job. All was well for two years, then I saw her with the complaint of a vaginal irritation. Examination revealed senile vaginitis and marked vaginismus. Topical estrogen and self-dilatation overcame these, then she developed trichomonas in the estrogen stimulated vagina. This was cleared up but she still protested that her problem was unrelieved.

Review of her domestic history elicited the fact that her husband had recently had a severe illness which depleted their savings. Because of his illness he lost his business and she had had to go back to work to support both of them. I advised her that I could offer no more help. She then developed bladder urgency and frequency and consulted a urologist.—Roland E. Bieren, M. D., Falls Church, Va.: *Virginia M. Monthly,* 85:187, April, 1958.

Staphylococcal Infections In Maternity Units

Staphylococcal infections in the nursery as well as in other areas of the hospital have become a major problem. The magnitude of these infections is such that maternity units in some hospitals have had to be closed by health authorities. To date, we have seen very little of this problem in Connecticut. Baldwin *et al* and Shaffer *et al* have shown that permanent carrier personnel have frequently been the source of an epidemic.—C. E. McLeod, M. D., and A. F. Turano, M. D.: *Connecticut Med.,* 22:596, August, 1958.

Some Pitfalls in Cardiac Management

MAURICE A. SCHNITKER, M. D.

IN this discussion about some pitfalls in the management of cardiac disorders I am not including the pitfalls of ignorance, but I want to take into consideration errors both of omission and commission. They can be many, and I shall try to categorize some of them. They are not necessarily the result of ignorance, but rather, because of the pressure of time, they occur often due to lack of attention to details. Both diagnosis and treatment of cardiac disease present such pitfalls.

Diagnosis

In order to treat any patient reasonably well, a proper diagnosis must be made. It has been well said, *first make the diagnosis, then proper treatment usually will follow.* Let us look at a few of the pitfalls in diagnosis of cardiac disease.

It is just as fallacious, and perhaps serious, to diagnose and to treat heart disease when it does not exist (iatrogenic) as it is not to recognize a cardiac disorder, and hence not to treat it, which may be fatal. In the first instance there is "overtreatment"; in the second instance "undertreatment."

In recognizing heart disease, there are several clues that can be very helpful. The first is the presence of cardiac enlargement. *An enlarged heart is not a normal heart.* Murmurs, particularly systolic in time, continue to be confusing to many. In general, a systolic murmur that is of grade 3 intensity, or louder, (based on Levine's classification of 1 - 6) usually means organic heart disease. There are exceptions, such as with anemia, or with thyrotoxicosis, and if they can be ruled out, the above principle is quite valid.

Under some circumstances, as with asthma, either cardiac or bronchial, it may be difficult at first to decide whether the heart is implicated or not. Unless the patient is in acute pulmonary edema, which should be obvious, another rule of thumb is to listen beneath the clavicles. If one hears the same rales and rhonchi in the subclavicular areas of the chest as one hears at the bases, one is dealing most likely with bronchial asthma. If the subclavicular areas are relatively clear, the condition is more likely congestive failure, or so-called cardiac asthma. Occasionally both may be present, chronic bronchial asthma with cor pulmonale and cardiac failure. If the facilities are available, a test of venous pressure and circulation time, rather easily done, can help to differentiate the two. And of course if cardiac failure is present it should be treated.

It has been my experience that careful observation of the ocular fundi will sometimes show slight distention of veins (over and above the 3:2 ratio of veins to arteries) early in congestive cardiac failure, even before there appears to be significant venous distention in the neck.

The appearance of arrhythmias may be an early clue to cardiac disease. In a normal sized heart, without murmurs, occasional extra-systoles, paroxysmal auricular fibrillation or paroxysmal auricular tachycardia may have no serious significance. Extra-systoles may mean more in an enlarged heart, and paroxysmal auricular fibrillation should make one look even closer for mitral stenosis, or hyperthyroidism.

Symptoms may be pitfalls, too, in the recognition of heart disease. Often one of the earliest symptoms, yet most difficult to evaluate, is fatigue. When an older person complains of noticeable ease of fatigue, after anemia and other obvious causes are ruled out, think of early cardiac insufficiency. Sometimes a brief therapeutic test with digitalis is warranted, what Christian used to call "tonic doses."

Cough, particularly when supine, is frequently an early symptom of congestive failure. As has been re-emphasized recently concerning cough with attention to cancer of the lungs, with a cough think also of early pulmonary congestion due to cardiac insufficiency.

Extra-systoles, too, are not always benign. The skipped beats of which the patient complains may be forerunners of auricular fibrillation and early congestive failure. Coupling, in the absence of digitalis, usually means cardiac disease in my experience.

Dyspnea is such a relative thing that it may be

Presented before the Southwestern Ohio Society of General Practice, under the auspices of the Greater Cincinnati Area Heart Association, Cincinnati, Ohio, January 19, 1958.

The Author

● **Dr. Schnitker, Toledo, is President of the Ohio State Heart Association; Director of Medicine and Chief, Medical Service, St. Vincent's Hospital, Toledo.**

difficult to evaluate. I do not make a diagnosis, but I keep seriously in mind conscious shortness of breath on two flights of 7 steps each, or less, as suggesting cardiac failure.

Systems Review

As I watch interns and residents begin to work on our medical service, perhaps the greatest pitfall of all, particularly in relation to diagnosis of cardiac disease but in all other disease states as well, is the failure to take any, or an adequate systems review in the history. In our program we teach it early, because if one does not learn to take a proper systems history then, one never does it and hence one never makes full and complete diagnoses. All too often as the present illness and past history are taken, a familial history is "glanced over" and the doctor hastens into the physical examination.

A neglect of a systems review, to "cut corners," usually to save time, leads to two serious consequences: (1) Missing causative phenomena, and (2) missing associated or other diseases. Concerning the first, to name but a few, if one asks about spontaneous epistaxes, frequent sore throats, or joint pains, or St. Vitus dance, one can often uncover a background of rheumatic fever, when in the past history the patient has denied rheumatic fever by name. Or, symptoms of "kidney trouble," or albumin, or nocturia, or episodes of burning on urination, may uncover renal disease as a background for hypertension one finds. Further, a history of recent tooth extraction, or operation on the gastrointestinal or genito-urinary tracts may lead one to the possibility of subacute bacterial endocarditis in the patient with valvular or congenital heart disease, fever and malaise.

Concerning the second, the missing of associated or other diseases, in older people, and particularly in those with coronary artery disease, one should look for diabetes mellitus. One misses entirely such symptoms as polydipsia, polyuria, pruritus, etc., unless a systems review is taken; yet, those may be late symptoms, or may not occur at all. The systems review further may bring out giddiness or occasional loose stools, which may develop earlier than the classical diabetic picture of polydipsia and polyuria. Unless one elicits symptoms of nervousness, sweating, palpitation, or husky voice, or dislike of warm or cold weather, or dry skin in a systems review one may overlook entirely the possibilities of hyperthyroidism or myxedema, and their associated cardiac conditions.

As you well know, anemia can be quite a burden to the heart. As Dr. Sturgis of Ann Arbor has shown,[1] the commonest cause of anemia is due to blood loss, and perhaps the most common of occult causes of blood loss is rectal hemorrhoids. The patient states "they bleed only occasionally," yet I have seen anemias with red blood cell counts under 3 million, when no one recognized this source of bleeding. And it is only through a careful systems review, that requires at the most 10 minutes, that these things are detected.

Other Clues

The pitfalls of electrocardiography in diagnosis is a subject in itself, so I shall mention only a few things. The greatest pitfall, as I see it, is reading too much into the tracing. Electrocardiography is invaluable, however, and a tracing usually should be taken. It matters a great deal who interprets the tracing. It is good discipline to try to determine the nature of a cardiac arrhythmia at the bedside, and it may be just as serious a pitfall not to get an electrocardiogram.

Recently I have seen two patients, who, to all intents and purposes at the bedside had auricular fibrillation. On the basis of a ventricular rate over 100, both had been given extra doses of digitalis. More careful scrutiny of the electrocardiogram revealed the presence of auricular tachycardia with block, which usually is caused by digitalis intoxication. That it may not always be due to digitalis was shown by the fact that the first patient improved on more digitalis; the second patient died very shortly thereafter.

At this point I should also like to inject a thought concerning a "cardiac examination." Time and again, doctors, as well as patients, want "just a cardiac examination," by which they mean auscultation of the heart and lungs, a blood pressure determination and an electrocardiogram. They seem to forget that the circulation is distributed throughout the entire body, and the heart must supply that entire circulation. Clues of cardiovascular disease may be found anywhere in the body. Hence a cardiac examination requires a good general examination.

I have dwelt at some length on diagnosis in the pitfalls of cardiac management to point up two important premises: (1) that a good cardiac evaluation of a patient means a good general examination including a systems review and (2) that the more accurate and complete a diagnosis, the better is the treatment apt to be, with fewer mistakes.

Therapy

In turning now to pitfalls in treatment of cardiac disorders, I should like first to mention the *medical paradox,* a situation not rare in medical practice. This refers to conditions in which one may have very similar symptoms, and signs, from "too much" as well as "too little." For

example, compare the symptoms of anemia and polycythemia vera. Both have similar fatigue, palpitation, headache, blurred vision, dyspnea, weakness, tinnitus, and tingling of extremities in their listed symptoms. On casual inspection the patients may not look too differently. Another example is hyperthyroidism and myxedema. Both may have nervousness, palpitation, dyspnea, edema and anemia. Of course there is a striking difference in appearance between exopthalmic goiter and advanced myxedema, but in the forme fruste varieties with such symptoms, it may be difficult to differentiate between the two.

Digitalis Paradox

But the principal example of medical paradox I wish to emphasize in our topic is the striking similarity in many respects between the patient who has had too much digitalis and the one who has had too little. Both can have dyspnea, even orthopnea, anorexia, nausea and vomiting, distended neck veins, rapid heart rate, enlarged and tender liver, pleural effusion, ankle edema, and extra-systoles, even bigeminy. In my experience, the failure to appreciate this medical paradox is an important cause for the overdigitalization of so many patients with heart disease.

With known auricular fibrillation, if the ventricular rate is over 100, generally the patient has not had enough digitalis provided you have ruled out (1) myocardial infarction, (2) hyperthyroidism and (3) primary or metastatic tumor of the heart, in all three of which the fibrillation may not respond well to any doses of digitalis. In the patient with sinus rhythm, and apparent cardiac failure, if the foregoing symptoms are known to have been present before digitalis was instituted, and with the drug there has been a lack of response with mitigation of symptoms, failure to induce diuresis, or to relieve dyspnea, there is probably under-digitalization. If one can feel satisfied that the above signs and symptoms appeared after the digitalis was started, there is probably over-digitalization.

If in doubt the electrocardiogram can be very helpful, remembering (1) that signs of digitalization in the ECG does not mean necessarily that the drug should be stopped; it does mean to "beware" and not to push the drug and (2) the electrocardiogram under digitalis can mimic almost any cardiac disturbance. Then if one is still in doubt, better to continue a maintenance dose, or even to stop the drug for two to three days and use the auxiliary measures, diuretics, correction of electrolytes, etc., under careful observation.

One might raise the question at this point, *when to digitalize?* When there is cardiac enlargement, easy fatigue and some dyspnea, a few basilar rales even with no ankle edema,—I believe digitalization is indicated. What is more, once a patient is digitalized usually maintenance dosage should be continued. If one waits to digitalize until there is overt evidence of failure, prominent distention of neck veins, many rales, even pleural effusion, and 3 and 4 plus peripheral edema, much valuable time has been lost.

Digitalis and Myocardial Infarction

In the patient with recent myocardial infarction, however, with tachycardia and a few rales at the bases, I do not digitalize because I expect some tachycardia from the irritable injured heart muscle and some rales from weakened heart muscle. Furthermore, a few years ago Katz[2] of Chicago demonstrated that if one routinely digitalizes patients with myocardial infarction the average mortality rate rises. In such cases one can concentrate on diuretics, a low salt diet, sedatives and the rauwolfia derivatives (for bradycrotic effect) and when digitalis is frankly indicated after myocardial infarction, as with auricular fibrillation, or with overt failure, it should be given but with caution.

Two other situations in which a therapeutic test with digitalis may be justified are (a) acute nephritis with edema, and (b) chronic bronchitis with emphysema and early (difficult to detect) cor pulmonale. Years ago Longcope[3] and more recently Murphy[4] have shown that practically 90 per cent of patients in the first category have, by careful measurements, evidences of some cardiac failure and should be digitalized. In the second group if it is decided to give digitalis, it has been our experience that small doses of digitalis are tolerated well and bring the best results.

Finally, Altschule[5] of Boston demonstrated an interesting thing several years ago that has not become widely enough known, namely, that many patients, to do best on digitalis, should be re-digitalized once, sometimes twice a year, by giving added doses of digitalis for three to four days at a time.

Now as to the choice of drug to use. With digitalis it is still the best policy *to choose two or three drugs, learn how to use them, and stick to them.* For the average case, powdered leaf is still among the best. Generally it is tolerated better by older people than are the purified glycosides. Since the powdered leaf is rather long acting, it is well to have on hand, and to know how to use, a short-acting preparation, such as Lanoxin®, and an intravenous preparation, such as Cedilanid.® In my opinion the intravenous use of digitalis is much overdone.

I believe digitalis intravenously may be used

(a) in acute pulmonary edema when the patient has had little or preferably no previous digitalis and (b) in cases of auricular flutter where no digitalis has been given within the past week, both rather rare circumstances because usually someone has given the patient some form of digitalis. Generally the drug given by mouth is sufficient, and if the patient is comatose, or is vomiting, intramuscular digitalis works very well. I am not recommending the use of acetylstrophanthidin to determine whether a patient is digitalized or not.

Diuretics and Electrolytes

Other treatments to supplement the use of digitalis in heart failure, such as the low sodium diet and diuretics, both the mercurials and the various carbonic anhydrase inhibitors and sulfonamides are producing pitfalls in therapy. Not long ago, before Dr. Christian died, a point had been reached in the study and treatment of cardiac failure, with the renal factors and electrolytes, to prompt him to remark that "It is beginning to look as though the heart may have nothing to do with cardiac failure."

Both diet and diuretics are sometimes used too little, more often used too much. That is, the low-salt syndrome, refractory states of failure, marked weakness, prostration and even death are becoming iatrogenic. We have had to learn that there is no one digitalizing dose for all patients. Now we have learned that mercurial diuretics are ineffective when used daily, and that if one uses a mercurial and a sulfonamide diuretic together, the one may check the action of the other with little or no diuresis resulting. And we have also had to learn that one can dehydrate a patient too rapidly as well as too much. These are all pitfalls to look out for. The major advances in diuretic drugs have produced less toxic agents, and much more effective ones than we used to have. So, unless the situation is an urgent one, good results are still obtained by oral digitalization of the patient over two to three days, and using, as necessary, a low sodium diet, with diuretics once or twice a week.

Another splendid advance has been a better understanding of fluid and electrolyte balance in diseased states and particularly in cardiac failure. At the same time it has opened another area for pitfalls in therapy. In the first place major electrolyte disturbances can result from too aggressive treatment; then the mistake is made of treating the electrolytes instead of the patient. I have seen more than one patient die with perfectly restored electrolyte balance by the usual tests. We do have to pay attention to them, the restoration of electrolyte balance may be lifesaving, but disturbances of sodium, potassium, chloride and calcium can be a part of the dying state, a problem not yet studied sufficiently. A few years ago Proger[6] studied the electrolyte patterns of several patients dying with cancer, and several cardiac patients who had been treated very conservatively by slow and properly maintained digitalization, with diuretics only once or twice a week, and found the electrolytes in all of them depressed; restoration of the electrolytes did nothing to alter their downhill course.

Sedation

Oversedation is another common pitfall in therapy. We prescribe sedatives to allay anxiety and to help make the patient comfortable. The patient often asks for more to escape reality. Then the intern and the nurse prescribe more so as not to be bothered during the night. All this adds up to slowed respiration, which may be harmful to the cardiac, with disturbed appetite and digestion and micturition, slowed venous circulation with resulting thrombophlebitis and pulmonary embolism, and sometimes a hastening of death. In such cardiac situations as acute pulmonary edema, or acute myocardial infarction, morphine, subcutaneously or even intravenously if necessary, is still the best drug to use.

Then there is the question of bed rest. We prescribe it for rest, but is it always so? It may be a two-edged sword. I have often told patients "seven days in bed makes one week (weak) regardless of how you spell it."

Let us stop to consider some of the hazards in the pitfall of too much bed rest. They may include constipation, distention, urinary retention, anorexia, bed sores, muscle wasting, cramps, phlebitis, negative nitrogen balance, loss of calcium and occurrence of renal calculi and mental depression. The patient's reaction to the strictness with which some cases of coronary thrombosis are treated may be summarized well by a friend's remark, "Go home some evening, doctor, have your wife tie your hands behind you, have her feed you, then have her bring you the bed pan from the ice box."

With other things being equal, it is well to allow the patient to dangle and to sit up as soon as he is able, and particularly if he wants to. If prolonged bed rest is necessary, particularly with a cardiac situation present, we have found it helpful to use the Wilkins' regime[7] of applying elastic stockings or wrapping the legs firmly with an Ace bandage, to prevent the occurrence of thrombophlebitis. If phlebitis does occur, we use the Homan's regime of placing the patient in the Trendelenberg position, with three pillows under

the head, which appears to lessen the incidence of pulmonary embolism.

Diet

Diet can be used very effectively in cardiovascular disorders. We starve the patient to lower the blood pressure, and we use a low sodium diet to get rid of edema and these measures work. But there are also several pitfalls. We are apt to overlook general dietary and vitamin deficiency often associated with chronic illness.[8] There is the economic factor. A chronic illness, such as cardiac disease, can be a severe financial burden to the breadwinner of the family. This results in less food, food of poor quality and improper balance.

Such chronic illnesses can produce a depression with resulting loss of appetite. Passive congestion of the gastrointestinal tract may cause more anorexia and indigestion with the further avoidance of food. When we add to that sometimes overdosages of drugs—digitalis, sedatives, ammonium chloride, etc. — these things can all lead to hypoproteinemia, anemia, more edema, loss of weight, and vitamin deficiency. The treatment for this pitfall is obvious once one thinks about it, with the attempt to relieve anxiety and despair, the elimination or change of anorexic drugs, the use of adequate proteins, vitamins of the B complex and proper ambulation.

Another important pitfall in therapy is the accumulation of drugs. It is a good rule to *review the drug schedule of treatment at periodic intervals.* Drugs pile up so easily, before one knows it the patient may be receiving 10 or 12 drugs, when two, three, or four properly thought out, would be ample. Then one always should know the contents and actions of each drug that one prescribes. In other words, *know what you are giving.*

The last pitfall that I should like to emphasize is the failure to recognize associated disease. It is a good maxim *to keep looking for other things, particularly those that are treatable.* Anemia due to blood loss is a good example. Long-standing anemia is a considerable load to the heart. Try to find the source of bleeding, correct it if possible, then build up the blood, and the results can be excellent.

In every patient that you see with angina pectoris, ask yourself four questions concerning factors in the pain:

(1) Is there anemia?

(2) Is there a thyroid disturbance, hyperthyroidism or myxedema?

(3) Is there aortic valve disease, stenosis or insufficiency?

(4) Is the pain all due to coronary artery disease?

The first two, one often can do something about. Keeping hyperthyroidism constantly in mind makes it much easier to recognize; the same with myxedema. *If you do not recognize myxedema in the patient the first time you see him you may follow that patient for years and never recognize it.*

Other Correctable Conditions

One should add to these the so-called "reversible forms" of heart disease, amenable to specific therapy. Anemia and thyroid disturbances have already been mentioned, but there is constrictive pericarditis, beriberi, and the whole host of congenital lesions that respond to specific surgery. And it is just as important to recognize, and to treat adequately, subacute bacterial endocarditis with a persistently negative blood culture.

To summarize briefly, there are pitfalls in overtreatment and in undertreatment of patients with cardiac disease, so one might reverse an old adage which says, "there are tricks to all trades"; in the practice of medicine "our trade is all tricks."

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Mercury Poisoning Outbreak In Ohio

An outbreak of mercury poisoning occurred in a small plant in Ohio in which classical symptoms of the disease were observed. Of the 36 employees who had the symptom "sore mouth," 22 had tremors or "shakes"; others had difficulty in writing and personality changes. The use of the Cornell Medical Index Questionnaire was effectively applied in the investigation.

There was marked contamination of the working environment and of the clothes of the workers to a mercury-copper amalgam tamping compound. The air concentration ranged from 1.0 to 7.5 mg. per cubic meter. Exposure was by inhalation, ingestion and absorption.

Blood and urine levels of mercury showed no direct correlation to symptoms of mercury poisoning. Higher levels in urine were generally found in persons with long exposure.—Dorothy Benning, R. N. M. S. W., Ohio Department of Health, Columbus: *Industrial Med. & Surg.,* 27:354, July, 1958.

The Problem of Pertussis

SAMUEL SASLAW, M. D., Ph. D., and CHARLES F. WOOLEY, M. D.

THE successful application of pertussis vaccines was first introduced by Sauer in 1933.[1] Despite the general availability of an adequate prophylactic agent for over two decades, whooping cough still presents one of the most serious of the acute communicable disease problems.

During the period from 1945 through 1956 a total of 46,131 cases and 457 deaths (1 per cent) were reported in Ohio (Table 1). These figures actually represent the trend rather than the true case rate since many cases are not reported, and deaths may be reported as the complication rather than the basic disease. During this same period 343 patients with pertussis were admitted to University Hospital (Table 1).

The higher mortality of 6.4 per cent (22 deaths) in the hospitalized group is not unexpected since the more actuely ill, and younger children with complications were referred to the hospital. Pulmonary complications, particularly bronchopneumonia or atelectasis were observed in 44 per cent; central nervous system complications such as encephalitis or hemorrhage occurred in 9.5 per cent. Nutritional complications due to vomiting occurred in 6 per cent of our patients. From the economic standpoint alone one can't overlook the fact that the average hospital stay of our patients was 12.1 days or a total of 4,150 hospital days.

As can be seen in Table 2, 79, or 23 per cent, of our admissions consisted of children three months of age or under; 142, or over 41 per cent, were not older than six months of age. In many communities immunization is not begun until the child is at least six months old. A total of 210, or 61 per cent, of the patients were under one year of age. It is remarkable to note that none of our patients had had complete pertussis immunization. In fact, most of the children had had no immunization, whatsoever. In reference to mortality, 19 of the 22 deaths occurred in children under two years of age, while 12 of these were actually under one year of age. Table 3 describes in more detail the 22 fatal cases. It is of interest to note that 14 of these patients died within 24 hours of admission after arriving at the hospital in a moribund state. Only one Negro mortality occurred, but in this particular study does not suggest a lower incidence since only 35 (10 per cent) of our admissions were Negroes, which is in proportion to the 10 to 12 per cent of non-whites in this area.

These observations tend to re-emphasize [2,3,4] the serious import and high incidence of pertussis and is not peculiar to Ohio. This situation is particularly distressing when methods are available for improving the problem. Under ideal conditions when all of the members in a stable community seek and receive early immunization for their children, exposure to whooping cough is minimized considerably. However, when there is a shifting population with an influx of people neglectful of immunization opportunities, the dis-

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TABLE 1.—*Incidence of Pertussis in Ohio and University Hospital 1945-1956.*

	Ohio			University Hospital		
		Deaths			Deaths	
Year	Morbidity	No.	%	Morbidity	No.	%
1945	7,742	106	1.37	30	2	6.7
1946	4,207	58	1.38	8	1	12.5
1947	10,451	83	0.79	59	2	3.4
1948	2,919	52	1.74	40	7	17.5
1949	3,696	29	0.78	35	2	5.7
1950	7,334	46	0.63	38	4	15.8
1951	2,127	17	0.79	34	1	2.9
1952	1,554	12	0.77	14	0	0
1953	1,437	17	1.18	13	0	0
1954	2,258	17	0.75	21	3	14.5
1955	1,885	15	0.79	37	0	0
1956	521	5	0.96	14	0	0
Totals	46,131	457	0.99	343	22	6.46

TABLE 2.—*Pertussis Morbidity and Mortality According to Age—University Hospital 1945-1956.*

Age	Morbidity No.	Morbidity %	Mortality No.	Mortality %
1 month	16	4.7	2	12.5
2 "	32	9.3	1	3.1
3 "	31	9.0	2	6.4
4 "	19	5.5	1	5.3
5 "	22	6.4	0	0
6 "	22	6.4	2	9.1
7 - 12 months	68	19.8	4	5.9
13 - 24 "	75	21.8	7	9.3
>2 years	59	16.9	3	5.2

TABLE 3.—*Pertussis Deaths—University Hospital, 1945-1956.*

Patient	Home	Year	Age	Sex	Color	Hosp. Days	Complications
1.	Cable	1945	6 mo.	F	W	9	Bronchopneumonia, encephalitis
2.	Columbus	"	1 yr.	F	W	1	Dehydration, bronchopneumonia
3.	Lynchburg	1946	7 mo.	M	W	1	Encephalitis, Dehydration
4.	Columbus	1947	2 yr.	M	W	1	Bronchopneumonia, cerebral edema
5.	Groveport	"	4 mo.	F	W	12	Bronchopneumonia, acute laryngeal edema, cerebral anoxia
6.	Washington C. H.	1948	7 wks.	M	W	5	Bronchopneumonia, atelectasis
7.	West Jefferson	"	19 mo.	M	W	1	Bronchopneumonia, atelectasis
8.	Washington C. H.	"	3 mo.	M	W	3	Aspiration pneumonia, atelectasis
9.	Columbus	"	3 yr.	M	W	1	Dehydration, cerebral edema, pulmonary edema
10.	Lancaster	"	14 mo.	F	W	1	Encephalitis, bronchopneumonia
11.	Jackson	"	11 mo.	F	W	1	Bronchopneumonia
12.	Lancaster	"	2 yr.	M	W	1	Atelectasis, bronchitis
13.	Columbus	1949	13 mo.	M	W	8	Atelectasis, bronchopneumonia, adrenal hemorrhage
14.	Columbus	"	3 yr.	F	W	1	Emphysema, bronchitis, cerebral edema
15.	Doanville	1950	3 mo.	F	W	1	Bronchopneumonia, cerebral edema
16.	Columbus	"	18 mo.	F	N	1	Bronchopneumonia, atelectasis
17.	"	"	6 mo.	F	W	3	Dehydration, uremia
18.	Chillicothe	"	3 mo.	F	W	6	Malnutrition, atelectasis
19.	S. Solon	1951	9 mo.	F	W	2	Bronchopneumonia, cerebral edema
20.	Galena	1954	21 mo.	F	W	1	Bronchopneumonia, cerebral edema chickenpox
21.	Frankfort	"	1 mo.	F	W	1	Bronchopneumonia
22.	Jackson	"	5 wks.	M	W	1	Bronchopneumonia

ease is presented a good opportunity to attack a susceptible population.

Control Principles

The following principles are suggested to decrease the morbidity and mortality due to pertussis:

1. Since most infants are susceptible from birth, all infants should be actively immunized as early as possible, starting at two to three months of age.[5, 6, 7]

2. Immediate passive protection with hyperimmume serum of any nonimmunized infant exposed to pertussis.

3. Follow through with boosters at the indicated intervals, especially in preschool children.

4. An ever present alertness by health departments and physicians of various communities as to the immune status of their community and particularly of newly arriving families.

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Accidental Death Statistics During Past Decade

Accidents, which have claimed an average of 93,000 lives annually over the past ten years, are responsible for 6 per cent of all deaths in the United States. Among persons one to thirty-six years of age, they are a leading cause of death.

Accidents play an important role in the mortality of the aged, a fact that may be overlooked because of the high incidence of chronic diseases in that group.

Among persons past age sixty-four, accidents cause between 25,000 and 26,000 deaths annually. Aging persons account for one out of every four accidental deaths.—*Minnesota Med.*, 41:535, August, 1958, as abstracted from *Patterns of Disease.*

Further Observations of Climatic Treatment of Hay Fever And Asthma with Special Reference to Florida

FRANK C. METZGER, M. D.

AN article of mine entitled "The Climatic Treatment of Hay Fever and Asthma, with Special Reference to Florida" appeared in *The Journal of the American Medical Association,* January 7, 1939 issue. An abstract was published by Dr. Morris Fishbein in his syndicated column. The Florida State Department of Health sent copies to people inquiring about asthma in Florida.

For some years I noted a definite decrease in patients sent to Florida for "climatic cure of asthma." In the past five years, however, there has been a steady increase in the patients I see who are told to come to Florida to get rid of their asthma or hay fever.

My experiments and observations since 1939 have caused me to revise my ideas on certain phases of this subject and have strengthened the others.

Since moving to another climate is a very serious matter, I feel that a review of this subject would be of value.

It seems obvious that if any change of climate were advocated for the cure or alleviation of *any* disease, one should first ascertain whether or not the natives of the new climate suffer from the disease in question. As far as allergy and its manifestations are concerned, I know of no such place. I have seen cases of asthma and hay fever in people who lived in Alaska, Africa, Hawaii, the Phillippines, China and Japan. I felt that no one should have asthma, especially of the inhalant variety, in the desert. But two women patients stated they had their first attacks of asthma when they were half way across the Sahara Desert. Four soldiers had severe asthma in Kunching, China, two had it in Death Valley.

Many allergic Floridians go to Arizona. Some get better, some get worse, the majority have no change. But I have had over a hundred allergic patients who came from Arizona to Florida seeking climatic relief. Some got better, some got worse and again the majority experienced no change. So we find that heat and cold, height or depth of the land, moist or dry climates are not the panaceas they are popularly supposed to be for asthma or hay fever.

Some Better, Some Worse. Why?

This being true, how then do we explain why some get well and some get worse? Many of these cases we can explain on a pure allergic basis; i. e., exposure or nonexposure to their specific allergens in the new place. The patient may inadvertently go to a place where his specific allergens are absent or at a minimum. If a person sensitive to ragweed moves from Indiana, Ohio, or any state with a high ragweed count, to Florida he should become almost symptom-free and be among those who "got better." The east coast of Florida is practically free of air-borne pollen. If, however, he made the opposite move and went from Florida to a midwestern state, he would be among those who "got worse."

Obvious Conclusions Are Frequently Erroneous

Many times the move is given credit it does not deserve. An eight year old boy with asthma and hay fever, lived in Fort Myers, Florida. The ragweed counts in Fort Myers then were 8 to 12 granules per cubic yard per day. At the height of the ragweed season, September 15, I received a letter from his mother. She stated she had taken the boy to Georgia to "get him away from the ragweed."

The ragweed counts in this city of Georgia were 500 to 600 granules per cubic yard per day. She reported the boy was much better." The facts were that neither from his history nor tests was he sensitive to ragweed pollen. His father was an alcoholic and his home life in Fort Myers was not good. I heard later from patients living in Fort Myers that the mother was advising all asthmatics from that area to go to Georgia, since the climate there had "cured her son." And, thus, the ball keeps rolling. Doctors must have facts to combat such ignorance.

If asthma and hay fever were all caused by the same allergens, this problem would be simpler and

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● **Dr. Metzger, well known allergist of Tampa, Florida, is a graduate of The University of Cincinnati College of Medicine who, before specializing in allergy, was in general practice in Waverly, Ohio (1916-1921).**

I could then conceive of a place where they were absent. But, it just isn't that way.

I have seldom seen an allergic individual sensitive to only one thing. I have seen many in whom one allergen was predominate, in which cases, avoidance or treatment for that one allergen resulted in freedom from symptoms. This would be one factor in the patients who see no change in their condition, i. e., they didn't get away from *all* their allergens. House dust is a sensitizing agent in a large per cent of sufferers from asthma and allergic rhinitis. In any climate people live in houses. Who then would expect them to fall into any other category than those who get no benefit from the change? In a warm climate people do get out of the house more hours per day, the windows are open, the dust is not so concentrated, hence their exposure is lessened. This would account for some cases who are better but not entirely free of symptoms.

In the past 18 years my experience from a clinical angle has not borne out my former conclusions; i. e., that our house dust was more potent than that found in northern homes.

Changes in Florida

There have been certain changes in Florida lately which have altered the picture I gave in 1939. Florida has grown immensely in population. Hence more houses, more yards, more roads, and since ragweed and cultivated grasses follow civilization, our pollen counts, especially for ragweed, have steadily increased and we now find that whereas in 1939 only individuals highly sensitized to ragweed and grass had trouble from these courses, in 1957 even those moderately sensitive have symptoms during the blooming period of ragweed and grass.

Thousands of acres in Florida are now fenced for cattle raising purposes and many have been planted to new grasses. Wild grasses are poor pollen producers, the cultivated grasses produce more. Along the fences ragweed grows where formerly in these uncultivated spaces no ragweed was found. I have not, as yet, observed any giant ragweed in South Florida. I now find that I have to increase the concentration of treatment doses for ragweed and grasses. I note no increase in the number of patients sensitized to tree pollens. In south and central Florida the oak tree is the predominant one whose pollen is sufficiently "widespread and abundant" to cause much trouble.

The number of manufacturing plants has increased bringing with them the usual smoke, fumes and dusts. The employees are exposed to occupational dusts and frequently those dusts, fumes and smoke affect patients living close to these plants. This factor, however, is very small compared to most northern cities, but in 1939 it could be ignored almost completely. Now some consideration must be given to it.

Longevity

Another factor has entered the picture. I refer now to the increase in longevity. The number of patients one sees who are past the four-score-and-ten span is increasing. In these cases one rarely sees pure, uncomplicated asthma or hay fever. Along with the allergy comes cor pulmonale, coronary thrombosis, arthritis, loss of elasticity of the musculature in the lung, emphysema, decreased resistance to infections and, last but not least, set convictions as to the action of various drugs and methods of treatment.

Convictions in elderly people are, in my experience, practically impossible to change, and so the psychological element of suggestion wipes out the use of many valuable drugs and methods. Most of these patients are on small fixed incomes and no honest physician can say anything to them to allay their fear of inflation.

In my former report I devoted one paragraph to the neurogenic or psychic element. My experiences have led me to believe that this element is accountable for a much greater part in the picture of results obtained than I formerly thought. I am struck with the frequency and poignancy with which they speak of their former homes, the friends and relatives they have left, the jobs or farms they have abandoned, their terrific disappointment that the climate had not stopped their asthma or hay fever as they had been led to believe it would. What are they telling me? They are indicating that they have exchanged the security idea of home, friends and familiar surroundings for the insecurity idea of a new home, strangers and unfamiliar sights and sounds. Do these things cause depression, anxiety and bodily feelings of discomfort and loss of vitality? The psychiatrists I consulted have without exception said yes, and more in older people than young ones.

That insecurity and anxiety enters the picture of the allergic individual has been quite well established.

Thermal Factors

There is a group where the psychological element helps. This group is comprised of those who are convinced that cold weather is the big or sole cause of their asthma. It is a fact that sudden drops in temperature are accompanied by spells of asthma in some cases. Why, we do not know. Since most people "practice medicine" and reach conclusions as to causes of their asthma, when there is some truth in a given circumstance, this conclusion becomes a

conviction, and convictions can become phobias. These people come to Florida or another warm climate. They get away from the physical effect of large drops in temperature and this acts as a defense mechanism.

My advice to physicians advising change of climate for relief of asthma remains unchanged; i. e., determine the allergens active in each given case, ascertain in what places said allergens are absent, diminished, or more easily avoided. To this advice, I now wish to add the following: The psychological effect upon the individual of a change should if possible be evaluated, for very frequently it can neutralize the good effect of diminished exposure to specific allergens.

Summary

Some allergic individuals can be helped by change of place. We can increase the percentage in this group if all factors are considered before advice to pursue such change is given.

Acetylcarbromal and Bromisovalum Not Habituating, Study Shows

A comprehensive review of medical literature and 371 case studies showed that two monoureide derivatives of carbromal, namely acetylcarbromal and bromisovalum, are not habit forming whether used singly or in combination. Sedayson® (a combination of acetylcarbromal 150 mg. and bromisovalum 100 mg.) and also acetylcarbromal 300 mg. and bromisovalum 200 mg. tablets, when used in full dosage over long periods of time, were negative as to the criteria of drug habituation.

Daily dosages of 6-8 Sedayson tablets, acetylcarbromal 1.8—2.4 Gm. or bromisovalum 1.2—1.6 Gm. were given. All patients were observed closely during treatment and for an adequate period of weeks after medication was discontinued.

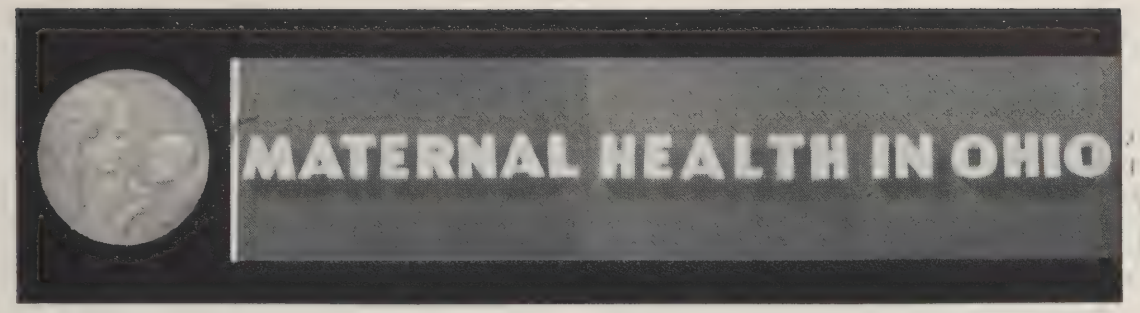
Because of a chemical relationship, the monoureides (carbromal, acetylcarbromal and bromisovalum) have been classified mistakenly as habit forming. However, one cannot predict the physiological action of a drug with any degree of certainty from its chemical structure. Due to the fact that the monoureide sedatives are not habit forming, have no side effects, no hangover and no contraindications, their use in combination is much preferable for continued use as a sedative or somnifacient to the dangerous and habit forming barbiturates.—Abstract: A Comparison of Monoureide and Diureide Sedatives with Respect to Drug Habituation, Untoward Effects and Mortality Rates, Feinblatt, T. M., Feinblatt, H. M., and Ferguson, E. A., Jr., *J. Nerv. & Ment. Dis.*, 125: 335; April - June, 1957.

Selective Readings

The Medical Interview, by Ainslie Meares, M.B.B.S. (*$3.50, C. C. Thomas Publisher, Springfield, Ill.)* It deals with motivation for the interview, the intellectual factors, non-verbal communication, rapport, passivity in the interview, hostility, suggestions in the medical interview, the physical examination, silences. This is a text that is needed in all fields of medicine because medical interviews of this nature form a very large part of medical practice. Unlike medical history taking, on the one hand and the psychiatric interview on the other, the medical interview refers to the discussion which takes place when it is some problem rather than a symptom which brings the patients to the consultation room.

Trace Analysis, by John H. Yoe and Henry J. Koch, Jr. (*$12.00, John Wiley & Sons, Inc., New York 16, New York.)* Presenting papers given at the 1955 Symposium, on the subject, at the New York Academy of Medicine. At a meeting of the scientific advisory board of the Sloan-Kettering Institute the subject of trace elements and the methods of analysis for them was brought up before the board. It soon became apparent that the subject had not received the cooperative effort it deserved as an un-unified field of science. Therefore, the Rockefeller Foundation and the Sloan-Kettering Institute decided to present this symposium in an effort to bring together for discussion different authorities and different disciplines from industry, agriculture, biology and medicine and to consider which of the various techniques would be directly applicable to the research investigation of the Sloan Institution.

New England Hospitals, 1790-1833, by Leonard K. Eaton. (*$6.00, University of Michigan Press, Ann Arbor, Michigan.)* This is a study of the impact of an institution on the people. Horace Mann, John Bartlett, John Adams, John Lowell, Josiah Quincy, and Dr. Eli Todd turned men's thoughts to the care of the mentally and the physically ill. People like the gentle mannered Dr. Jackson considered it their duty not merely to "throw a few pills and powders into one pan on the scales of Fate while Death itself was seated in the other, but to lean their whole weight on the side of Life and shift the balance in favor if it lay in human power to do so." In these early days the hospital was, as it is in our times, an institution devoted to healing the sick, a center of research and learning and a challenge to the architect and the rounds of endless financial and administrative struggles in growth. Dr. Eaton places this development in a cultural perspective.



THE primary purpose of this column is to present suitable material pertaining to obstetrics as a "refresher" program for the information and education of Ohio physicians who practice obstetrics.

After browsing over the wealth of data contained in the case files of the Ohio Maternal Mortality Study, the chairman of the Committee*, impressed with interesting material concerning *postmortem cesarean section,* desires to present some of the statistics on the subject. This is not to be considered as a personal accomplishment, but rather in a sense of pride focused upon members of the Committee, and numerous other physicians throughout Ohio who have contributed generously to the project, in both time and effort.

Cesarean section has always been one of the most dramatic procedures in the armamentarium of the surgeon. Even more exciting is the same operation which salvages a living infant from its dead mother, although it represents the oldest application of this famous operation.

Background

A moderate amount of material has appeared in the literature concerning this topic. Kelly[1] and co-workers presented an excellent summary of the literature with a history of the operation; they reported 111 successful postmortem cesarean sections from a survey of world literature, and added two cases. DeKruif[2] and associates reported a successful case, and stated that from 1950 to 1954 the Minnesota Mortality Study reported 14 postmortem cesarean sections without the survival of a single infant. Weil[3] et al. (Akron, Ohio) reported four postmortem cesarean sections at City Hospital, with two infants surviving a year or more; two operations were unsuccessful. However, none of these four is contained in the files of our Ohio Maternal Mortality Study, hence they are not listed in the 25 cases mentioned in this article.

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

TOPIC THIS MONTH:

Maternal Deaths* With Postmortem Cesarean Section

The Ohio Study

Since January 1, 1955, when maternal mortality cases were first collected for the Ohio Study,* a total of 408 cases have been compiled to date. Some which were acquired recently have not yet been reviewed by the Committee, hence they are not classified as "maternal death" or "non-maternal death."

Among the 408 cases, there were 25 postmortem sections, listed in table 1, which resulted in the delivery of nine living infants (including one set of twins.)

If the figures were corrected, omitting the group

TABLE 1. *Fetal Results, According to Length of Gestation, 25 Postmortem Cesarean Sections. Ohio State Maternal Mortality Study.*

Less than 28 weeks gestation:	**(5)**
Case	61—stillborn
"	119—stillborn
"	195—alive, lived 15 minutes
"	231—alive, lived 2 hours
"	256—stillborn, macerated
From 28 to 36 weeks gestation:	**(5)**
Case	79—stillborn
"	137—stillborn
"	159—stillborn
"	172—stillborn
"	225—stillborn
From 36 to 39 weeks gestation:	**(7)**
Case	44—stillborn
"	59—stillborn
"	211—alive, lived 2 hours
"	229—stillborn
"	264—alive, lived 1 hour
"	274—alive, lived 1 hour
"	304—stillborn
From 39 to 40 weeks (term):	**(8)**
Case	9—stillborn
"	76—alive, no follow-up
"	132—stillborn
"	157—alive (twins) & well now
"	164—stillborn
"	193—stillborn
"	194—alive & well now
"	207—stillborn

below 28 weeks gestation, there would be 20 postmortem cesarean sections, with a salvage of seven living infants (including one set of twins.) An effort was made to ascertain the condition of the living infants, over a period of time. Of the seven living infants, three have survived and are healthy today, one was impossible to follow-up, and three (from the 36 to 39 week category) died two hours or less after delivery. This indicates a survival rate of 15 per cent of the total possibilities in 20 cases, or three of the seven born alive through postmortem cesarean sections survived two or more years.

The *eight* cases of postmortem cesarean section which salvaged a living fetus (one had living twins) are briefly summarized below, to depict the terminal clinical signs and the cause of the mother's death:

Case No. 195

A 21 year old, white, gravida II, Para I, who died at 26 weeks gestation. Her prenatal care was adequate; she was a known case of Hodgkin's disease, with extensive treatment. Suddenly she developed dyspnea, chest pain, was hospitalized and died. An immediate postmortem cesarean section delivered a living fetus (no weight) which survived 15 minutes. *Cause of death* (no autopsy): cardiac failure; pulmonary edema; Hodgkin's disease. Non-maternal death.

Case No. 231

A 29 year old, white, gravida III, Para II, who died at 26 weeks gestation. Her prenatal care was adequate; she was known to have bronchial asthma. Suddenly she developed dyspnea, cyanosis, "terminal congestive heart failure" and died. An immediate postmortem cesarean section delivered a living fetus (no weight) which survived for two hours. *Cause of death* (no autopsy): Acute bronchial asthma; allergy; circulatory failure. Non-maternal death.

Case No. 211

A 31 year old, white, gravida IV, Para II, abortus I, who died at 36 weeks gestation. The prenatal care was adequate, with prompt treatment of pre-eclampsia; she had had eclampsia with a previous pregnancy. Hospitalized for therapy of progressive toxemia in the 35th week, the patient improved only briefly, then she suddenly convulsed, became dyspneic, cyanotic and died. An immediate postmortem cesarean section delivered a living fetus 6 pounds, 9 ounces, which survived two hours. *Cause of death* (no autopsy): Cardiovascular accident; hypertension; toxemia of pregnancy. Maternal death.

Case No. 264

A 42 year old, white, gravida II, Para I who died at 36 weeks gestation. She received adequate prenatal care. In her third trimester she was treated in the hospital emergency room for a strangulated umbilical hernia; it was reduced after she was admitted to the hospital. Soon she developed nausea, nasal hemorrhage, later abdominal distension, pulmonary congestion and finally generalized rigidity and cyanosis. She died on her 21st hospital day. An immediate postmortem cesarean section delivered a living 6 pound fetus which lived one hour. *Cause of death* (autopsy): Pulmonary infarction; bronchopneumonia; atelectasis. (Case not reviewed.)

Case No. 274

A 30 year old, white, gravida III, Para II who died at 36 weeks gestation. She was a known cardiac case, and received exceptionally good prenatal care with bed rest etc. Suddenly she became dyspneic, was hospitalized and in spite of vigorous treatment she died 12 hours later, in congestive failure. Immediate cesarean section delivered a living fetus (no weight) which survived one hour. *Cause of death* (no autopsy): cardiac failure; rheumatic heart disease. (Case not reviewed.)

Case No. 76

A 35 year old, white gravida VI, Para V, who died at 39 weeks gestation. She was said to have had adequate prenatal care, yet visited her physician only several times; no toxemia was noted, and no laboratory studies were recorded. Admitted to the hospital with dyspnea and profuse sweating, the patient pursued a downhill course and died, apparently of congestive failure; no convulsions were noted. Immediate postmortem cesarean section delivered a 7 pound living fetus which survived (no follow-up since father removed it from hospital). *Cause of death* (no autopsy): Acute cardiac failure; eclampsia (?); myocarditis. Maternal death.

Case No. 157

A 24 year old, white, gravida III, Para II, who died at term. Prenatal care adequate. Last week of pregnancy x-ray revealed twin pregnancy with "interlocking chins"; surgical consultation recommended cesarean. Elective operation scheduled; a low spinal anesthesia of Pontocaine® was administered, and followed by 3 cc. Sodium Pentothal® (1 Gm./20cc), whence the patient's heart and respirations ceased. Oxygen and artificial respiration were administered, and immediate cesarean section delivered living twins, 8 pounds and 6 pounds 8 ounces, which are alive and well in 1958. *Cause of death* (no autopsy): respiratory paralysis during induction of anesthesia for cesarean operation. Maternal death.

Case No. 194

A 27 year old, white, gravida VII, Para IV, abortus II, who died at term. Prenatal care was adequate. Patient began labor spontaneously and was admitted with ruptured membranes. Labor was irregular, not progressive. X-ray studies revealed no gross pathology. Several doses of Pitocin® (½ minim) were administered with no effect, and were not repeated. It was elected to perform a cesarean section but while the operating room was being prepared the patient suddenly became dyspneic, and cyanotic; oxygen was administered on the way to the operating room. Approximately three minutes after death a cesarean section was performed delivering a 6 pound 4 ounce living fetus. The baby is alive and well in 1958. *Cause of death* (autopsy); amniotic fluid embolus, pulmonary; left hemothorax; retroperitoneal hemorrhage; cervical tear. Maternal death.

Comment

It is possible that the living infant delivered in **Case No. 76** is still alive and well, although all efforts to trace the case were futile. Nevertheless, it can be seen that the closer to term the gestation progresses, the better the chance of fetal survival after postmortem cesarean section. However we quite agree with Weil[3] as he states, "Any gestation progressed beyond the 28th week should be given every possible chance of survival." He further states that if signs of fetal life were present shortly before the mother's death, we should assume the fetus is alive and immediately deliver it. "Legally we are not justified in delaying for the purpose of obtaining operative permits."

The circumstances present in **Cases 157 and 194**

just prior to death of the mother seemed more or less "ideal" (if that term may be used) for a prompt postmortem cesarean section with fetal survival. On the other hand, it has been pointed out by Kelly[1] (quoting Eastman) that the length of infant survival is profoundly diminished by conditions such as chronic illness or wasting disease of the mother, especially when the terminal events produce cyanosis.

If we shall attempt to save a living fetus from *certain* death within its dying mother, we must make a prompt decision and intervene at once! "Mere statistics should not discourage one from attempting this procedure (postmortem cesarean section) despite most trying circumstances," DeKruif[2]. The seven *living* infants, with three (and perhaps a fourth) surviving and healthy today, out of 20 postmortem cesarean sections in the Ohio State Maternal Mortality Study would certainly indicate that a more favorable attitude should be developed towards this procedure.

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Tolbutamide Compared to Insulin For Diabetic Control

Tolbutamide does not facilitate glucose utilization. It does not directly influence other hormones except the hypoglycemic effect of insulin, nor do other hormones affect it. It is not an insulin substitute and one would wish to determine its ultimate value in diabetic management, because disturbances in fat and protein metabolism, as well as carbohydrate metabolism, are significant defects of the disease. Clinically we measure only hyperglycemia and ketosis, yet we know both protein and fat metabolism are profoundly affected by insulin and lack of it.—Howard M. Hackedorn, M. D., Seattle: *Northwest Med.*, 57:749, June, 1958.

Postural Hypotension

Following surgery, postural hypotension may occur and last for several weeks. However, even though the physiologic changes are profound, readjustments occur in a matter of months with a disappearance of unpleasant symptoms. Response to drugs is more pronounced and sensitive, even with smaller doses.—Peter Hywelris Jones, M. R. C. S., L. R. C. P., Lexington, Ky.: *J. Kentucky State M. A.*, 56:562, June, 1958.

The Effect of Antimetabolites On Embryonic Development

The experiments to date, which are preliminary in nature, have given us experience in the effect of antagonists on enzyme systems important in neural development. By this technique, one may interfere with a known neural enzyme system, study its effects on the developing organism and compare the results with what may be occurring in nature by chance. One may produce an acute dietary deficiency by blocking an essential vitamin during the gestation period of the mother, or for that matter, one may block any known neural enzyme system. In this way one may simulate that which might be occurring spontaneously in nature.

There are many naturally occurring antimetabolites which may be taken in excess amounts during the vagaries of appetite of the mother during her pregnancy to the harm of the growing offspring. Of the antimetabolites under study we know that there are naturally occurring substances antagonistic to the vitamin thiamine, and indole-3 acetic acid is a naturally occurring plant hormone.

By this same technique we are able to study the effect of drugs which are given in treating some disease processes; in this instance, isonicotinic hydrazide used in treating tuberculosis. Moreover, by this technique we can study substances that may be produced within the organism itself and absorbed as a foreign substance such as tryptamine in the colon which is formed by bacterial action.

Of considerable importance is that the amount of any of these substances given to adult animals was so small as to cause no detectable physiological or psychological effects, whatsoever. However, the effects on the embryos, in their development, were devastating.

Continuation of this area of research, then, has for its objective the elucidation of factors which interfere with the normal development of the neural system of the embryo and result in pathological states clinically characterized as mental retardation, cerebral palsy, or convulsive disorder. We have a long way to go but the road looks open and the highway offers excitement en route. —Jacques S. Gottlieb, M.D., Charles E. Frohman, Ph.D., and Joan M. Havlena, M.A.; Detroit: *J. Michigan M. Soc.*, 57:364, March, 1958.

Intestinal Polyps in Children

It behooves all of us to search diligently for possible polyps in any child with blood in the stool, diarrhea, recurrent abdominal cramps or history of mass prolapsing from the anus.—Robert H. Burt, M. D., *Northwest Med.*, 57:1004, August, 1958.

Herpes Gestationis: Report of a Case*

WILLIAM E. SPRAGUE, M. D.

HERPES GESTATIONIS is an uncommon complication of pregnancy. Because of this the author feels that this presentation would be of interest to the medical profession.

The patient, a 23 year old primagravida, had had an uneventful prenatal course until five days prior to her expectant date of confinement, May 8, 1957. At this time she noticed the eruption of small erythematous papules around her umbilical area which became vesicular and spread rapidly over the abdomen within four days.

Blood pressure, urinalysis, and blood count were normal. A diagnosis of herpes gestationis was made. She was placed on Aureomycin® ointment and Aureomycin capsules, 1 four times daily, and advised to keep her fingernails short. The papulovesicular eruptions spread to her back and symmetrically down her legs. She remained afebrile and the fetal heart tones were good.

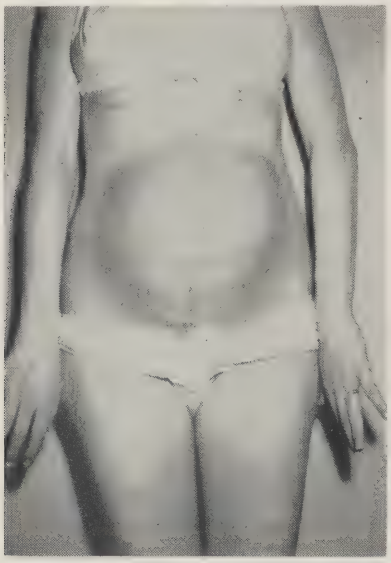


FIG. 1. Patient on second postpartum day showing confluency of lesions over abdomen.

In my review of the meager literature it is reported that although maternal prognosis is good there is some danger to the fetus, perhaps due to a viremia, although the etiology remains obscure. Because of this jeopardy, a medical induction of Pitocin® drip was begun on May 10, and a viable infant was delivered spontaneously nine hours after beginning the induction.

*From the Obstetrical Department, Sheltering Arms Hospital, Athens, Ohio.

The Author

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Her postpartum course was noted by continual spread of the lesions across her chest, symmetrically down her extremities to her hands and feet. By the fifth postpartum day the entire body was involved with the exception of the face which never became affected. Meticorten® 5 mg. four times a day was begun on the fifth postpartum day. The lesions became confluent first about the abdomen, and gradually throughout the remainder of the body—the lesions first appearing, disappearing first. At 12 days postpartum the skin was completely clear, the disease having lasted for a total of 17 days.

It is to be noted that although the Aureomycin did not halt the spread of the disease, secondary infection was prevented as the patient's course was entirely afebrile and nontoxic. Meticorten was used to prevent any post-herpetic scarring and this too was achieved.

Acknowledgment: Consultation acknowledgment is gratefully made to John C. Ullery, M. D., Columbus, Ohio, and F. C. Prunty, M. D., Parkersburg, W. Va.



FIG. 2. Second postpartum day showing symmetrical distribution of lesions on posterior aspects of legs.

Developmental Anomalies

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

Shortly after birth it was recognized that this 5 year old child suffered from bilateral aniridia. The appearance was entirely typical, with no visible iris in either eye. Absence of the foveal light reflex indicated coexistence of the frequently associated anomaly of macular maldevelopment. Nevertheless, vision seemed quite adequate for the childhood requirements of eating, walking, playing, recognition, etc.

At about the age of 4½ years there seemed to develop a hesitancy in behavior and a reluctance to play with small things. During the following six months this situation became worse and the parents recognized that their child was not seeing as well as formerly. When the child was brought for examination, vision seemed limited to light perception only, the optic nerves were deeply excavated and atrophic, and the intraocular pressure was over 50 (twice normal).

Discussion

The assumption that all developmental anomalies are untreatable and irreversible is certainly unwarranted. Aniridia is a good example of a disorder which requires careful follow-up in order to avoid predictable serious complications. Quite commonly glaucoma develops in association with aniridia. Because of this known association, intraocular pressure should be checked periodically during childhood in such patients. Surgery is frequently quite effective in controlling this type of glaucoma. Failure to detect glaucoma through suspicion and routine tonometry led to the blindness of the aniridia patient described.

Crossed eyes present at birth represent another good example of preventable visual loss. Should the child exhibit preference for one eye, the other, unused, eye may develop severe suppression of vision. Recognition of the monocular nature of this strabismus will present an opportunity to save vision through proper occlusion therapy.

Congenital glaucoma almost invariably leads to blindness unless proper surgery is done promptly. The important thing is recognition of the glaucoma, which is simplified by the fact that these children usually have enlarged corneal diameter (greater than 12 mm.). "Great big pretty eyes" are not good! Often rents occur in the posterior corneal surface and cause the corneas to become quite steamy and opaque. Corneal enlargement or opacity at birth or during childhood should arouse suspicion of glaucoma and indicates prompt care.

The Author

● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

Iridocyclitis or chorioretinitis may occur during infancy or even prenatally. Therapy is with mydriatics and steroids just as in adult life, and is often very effective. Mistaking such inflammations for stationary congenital anomalies is possible, and leads to serious neglect. The syndrome of congenital toxoplasmosis with macular chorioretinitis, intracranial calcification, convulsions, and hydrocephalus is well established.

Almost no one realizes that much can and should be done even for the ultimate eye anomaly of anophthalmos or severe microphthalmos. Without the stimulus of an eye, the lids and socket will not develop properly and the cosmetic end result is very poor. Beginning during infancy a plastic prosthesis should be fitted to the eye socket. Gradual enlargement of this prosthesis will result in a fairly normal socket with presentable lids. Surgery on a neglected socket and lids in adult life will never result in as nice appearance as will this early care.

Among the causes of microphthalmos is rubella occurring during the first trimester. Deliberate exposure to German measles during childhood is wise prophylaxis for little girls. Some reports indicate benefit from gamma globulin given a pregnant woman immediately after exposure to rubella.

Retinopathy of prematurity (retrolental fibroplasia) is now well recognized as a defect easily prevented through avoidance of excessive oxygen.

The rare anomaly of galactosuria results in bilateral cataract formation which can be avoided simply by the elimination of milk in all forms from the infant's diet.

In summary, many types of developmental anomalies of the eye benefit from prophylactic treatment and careful observation.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 25 year old white male entered University Hospital, Columbus, Ohio, with the chief complaint of general weakness. The patient had always been in good health until five weeks prior to admission, when he developed a sore throat and fever. Penicillin brought relief after about one week. His appetite had been poor and he had tended to be constipated since the onset of symptoms. He then developed general weakness, easy fatigability, and his fever and sore throat reappeared. He was reported to have drunk about a pint of tar remover four weeks prior to admission but admitted to no other contact with drugs or chemicals. His urine was reported to have been dark during the last two weeks prior to admission.

His local physician found him anemic and he entered a local hospital, where blood and bone marrow examinations were done. His hemoglobin was 7.8 Gm.; white blood count was 1,950 with 52 per cent lymphocytes, 4 per cent monocytes and 44 per cent neutrophils. Platelets were apparently adequate in number, and his temperature was 102° F. He apparently did not have hepatomegaly, splenomegaly or lymphadenopathy, and he was transferred to the University Hospital. There was no family history of diabetes or tuberculosis. He was a moderate drinker (up to 6 pints of beer daily) and smoked an average of one pack of cigarettes daily.

Physical Examination

The patient was a muscular while male in no distress, alert, and was ambulant on admission; temperature was 100° F., respirations 24, blood pressure 102/54. His skin showed a fine maculopapular rash over the back, but no petechiae, bruises or jaundice. There was no superficial adenopathy. There was no evidence of throat infection; no gingival lesions were noted. His pupils, fundi, ocular movements and visual fields were normal. His lungs were clear to percussion and auscultation.

The heart showed the position of maximal impulse 8 cm. from the midsternal line in the fifth intercostal space. A grade I to II blowing systolic murmur was heard over the pulmonic and aortic areas and showed no radiation; the second aortic sound was greater than the second pulmonic. The heart rhythm was regular. Abdominal examination showed a firm spleen enlarged to 3 cm. below the left costal margin. The liver and kidneys were not palpable and no tenderness or abdominal masses were felt. Bowel sounds seemed normal in quality. The remainder of the physical examination revealed nothing abnormal.

Presented by

- B. K. Wiseman, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus.

Edited by Dr. von Haam.

Laboratory Investigations

The hemoglobin was 9.6 Gm., red blood cell count 3.01 million; reticulocytes 0.2 per cent; white blood cells 600 with 10 per cent polymorphonuclear leukocytes, 76 per cent lymphocytes and 12 per cent monocytes; platelets numbered 318,240. No abnormal red or white cells were observed. Hematocrit was 32 per cent; sedimentation rate was 26 mm. in 60 minutes. Bone marrow examination showed an increased cellularity consisting mostly of normoblasts with normal appearing megakaryocytes and small numbers of normal lymphocytes; myeloid elements were sparse and mature granulocytes were inconspicuous.

Tests on blood for specific auto-antibodies against white cells were positive in a dilution of 1:64. Direct and indirect Coomb's tests were negative. Serologic tests for syphilis were negative. The urine had a specific gravity of 1.028 and was negative. Stool was guaiac-negative. The blood urea nitrogen was 22 mg.; blood sugar 122 mg.; van den Bergh direct was 0, indirect 0.5 mg.; thymol turbidity 10 units; cephalin flocculation 2 plus; total serum protein 6.9 Gm. with an albumin/globulin ratio of 3.9:3; serum cholesterol was 122 mg.; sodium, potassium and chlorides were normal; inorganic phosphorus was 5.8 mg., alkaline phosphatase was 1.9 units.

Three 24-hour fecal urobilinogen determinations showed 85 mg., 116 mg. and 250 mg. per total weight. Bromsulphalein test on the sixth day was

negative. Heterophil antibody test on the fifth day was positive to a titer of 1:56. Guinea pig absorption was positive in 1:7 dilution. Two febrile agglutination tests for typhoid, paratyphoid and Brucella organisms were negative. Two blood cultures were negative.

Radiologic Studies

Four days after admission radiologic examination showed a normal heart, normal lung fields and a normal upper urinary tract. The examination of the gastroduodenal tract revealed only the presence of a large spleen pressing on the stomach.

Hospital Course

The patient's general condition remained unremarkable during the first six days in the hospital. However, on the sixth day he started to show an afternoon pyrexia and by the ninth day he was having a remittent fever ranging between 99° and 104°, with corresponding rises in pulse and respirations. At this time his total white count was 650 with 30 per cent polymorphonuclear leukocytes, 30 per cent small lymphocytes and 40 per cent monocytes. His red blood cell count was 2.76 million with 1.4 per cent reticulocytes and a hemoglobin of 8.4 Gm. His platelets numbered 193,000.

On the 12th hospital day he was seen by a surgical consultant because of the development of a severe, knifelike pain over lumbar 3 and 4 areas, followed by bilateral lower abdominal pain. No nausea occurred and no shoulder pain was felt. He had a temperature of 104.6° and his abdomen was rigid. His bowel sounds were decreased. The serum amylase was 97 and he had passed three rather loose stools that day. A blood culture was negative, and stools yielded numerous coagulase-positive Staphylococci. An upright film of the abdomen showed many air and fluid levels within the colon and a few within the small bowel. Surgical intervention was not deemed indicated.

At this time he was on erythromycin, 500 mg. four times daily, and 2 cc. of Combiotic® daily from the initial rise of temperature. He was given 3 units of whole blood and 1 liter of dextrose in water. His condition failed to improve and his pyrexia, tachycardia and increased respiratory rate persisted. He became semicomatose, and the jaundice, which had been developing, progressively deepened. During the last three days he vomited small amounts of dark blood and was incontinent of small amounts of tarry stools. He was also coughing up small amounts of blood-tinged sputum. His right chest became dull to percussion posteriorly and breath sounds over this area were somewhat diminished. He expired quietly on his 16th hospital day.

Clinical Discussion

DR. WISEMAN: This is indeed a most fascinating case and I think that if I could team up with a Pinkerton detective I might make better progress. My thinking has chiefly evolved about the possible connection between the tar remover he allegedly drank and the subsequent events. All the tar removers that I know anything about have benzol in them. I don't believe anybody can drink nearly a pint of this liquid without getting some complaints from his stomach and bowels, and there is no statement that he had an acute gastroenteritis. Perhaps he just spiked his beer a little bit with a drop or so of benzol. It is not an uncommon practice to put some ether or other things into your drink in order to get a kick out of it, and you can get a kick out of benzol. As I say, a Pinkerton detective would have been very useful here in hunting down the details in respect to that tar remover.

His difficulty started about two weeks prior to his admission to University Hospital. He had a sore throat and a fever for which penicillin seemed to be helpful. About that time his blood count revealed a marked leukopenia and a moderate anemia. Obviously something was happening to the blood-forming organs at that time, and the lack of sufficient leukocytes I think would account for his fever and the infection of his throat, which was effectively controlled by penicillin. At this time he did not have any enlargement of the spleen, liver or lymph nodes and apparently got over that one episode quite well. He was then admitted to University Hospital for some additional investigation of his blood picture.

Hospitalization

When he entered University Hospital he showed no surprising clinical signs or symptoms except that he did have a palpable spleen extending about 3 cm. below the left costal border. Three centimeters below the costal border may vary a good deal from one person to another, but it would be a spleen that should certainly weigh over 300 Gm. and perhaps as high as 600 Gm. His systolic murmur heard in the pulmonic and aortic areas of the heart was probably a functional type of murmur explainable by his anemia.

His peripheral blood showed a pancytopenia, and his white count was certainly not compatible with life for a very long period of time. But no abnormal cells were seen. The platelets were reduced by about 25 per cent. The bone marrow picture is rather unusual, I think, in view of the pancytopenia of his peripheral blood. It showed

an almost specific granulocytopenia. Very few myeloid elements were present, but many nucleated red cells and normal megakaryocytes. I would like to warn you at this point that the bone marrow does not always reflect the true state of hematopoiesis. There are many hematologic dyscrasias in which the marrow appears pretty normal while the peripheral blood reveals severe difficulties in the production of these cells.

With the evidence we have from his peripheral count, we can assume that his marrow also had difficulties in producing red cells and platelets in spite of its normal cellularity with respect to the normoblasts and megakaryocytes. His serum contained specific auto-antibodies against white cells demonstrable in a dilution of 1:64, which is fairly strong by that particular technic. The titers seldom go higher than 1:128, and I would consider a titer of 1:64 quite indicative and reliable.

Afternoon Temperature

In his first six days in the hospital nothing remarkable happened. He then developed an afternoon temperature and a remittent type of fever, and I would rather think that he was again showing signs of a secondary infection due to his very low neutrophil count. His platelets had dropped to 193,000. On the 12th hospital day he had a severe knifelike back pain followed by bilateral lower abdominal pain, which I consider the sort of muscular pain that you see in infections. He was running a pretty high fever and his abdomen then became rigid, probably through muscle spasm or myositis. The surgical consultant felt that he did not have any intraabdominal lesion which warranted surgery.

One wonders about the significance of the coagulase-positive staphylococci found in his stools and what relationship this finding might have to his demise. He had not many signs of an enteritis, but the staphylococci might have played an important part in this man's death in conjunction with his pancytopenia. Then his van den Bergh started to rise and he became rather severly jaundiced and semicomatose.

The question of why he became jaundiced should perhaps not be too difficult to answer. I think that his jaundice was due to liver failure from toxemia. I don't know what the liver might show pathologically, but I expect some changes in the parenchymal cells. There is no reason to believe that he had obstructive jaundice. His platelets got lower and lower and he developed spontaneous hemorrhages in various places including his bowels, and he expired.

I am going to stick to my opinion that the benzol was responsible for this man's fatal illness. But in the differential diagnosis you certainly have to consider other things which would cause a pancytopenia and a collapse of his bone marrow. Of course benzol does cause an aplastic anemia and it does it quite often. There are several kinds of aplastic anemia: those induced by a long list of drugs headed by benzol or compounds with the benzol ring, and the so-called idiopathic aplastic anemia the cause of which is unknown. Our case fits aplastic anemia and the only reason to give it a specific etiological factor here is the rather acute course of the disease. The idiopathic types usually go along for a considerable time. This, however, was rather acute and on that basis alone should be related to some toxic agent.

What about agranulocytosis? Our modern theory about agranulocytosis is that this is an autoimmune type of disease and auto-antibodies have been demonstrated in agranulocytosis of Pyramidon® etiology. I don't believe this is agranulocytosis because all other blood cells almost disappeared from his peripheral blood.

There is a disease known as cyclic neutropenia, in which the neutrophils will disappear, the spleen will enlarge, and the patients will have a lot of fever and a lot of secondary infection. But just about the time you are beginning to worry whether the patient is going to get well or die, the neutrophils come back spontaneously for some unknown reason and all the symptoms disappear. However, this man did not recover but went progressively downhill and died.

Monoblastic Leukemia

In a case like this I always think of monoblastic leukemia. We have had most bizarre experiences with cases of monoblastic leukemia, and I feel quite definitely that individuals have died on our service of monoblastic leukemia in whom only a few monoblasts were present in the bone marrow and none in the blood. I doubt very much the possibility of monoblastic leukemia in this case. I think the bone marrow would be the strongest evidence against it in that there was no mention of immature cells in the marrow.

We come next in our differential diagnosis to our old friend Hodgkin's disease. Hodgkin's disease is the pathologist's trap for internists, as it can have a most unusual clinical course. In a case like this, with fever and some degree of splenomegaly, and with collapse of the bone marrow and pancytopenia, you could never rule out Hodgkin's disease with certainty short of a complete tissue examination of the body. However, patients with Hodgkin's disease usually have a pretty cellular marrow and I think that a collapsed marrow would be the one strong point against Hodg-

kin's disease. The total course of the disease, lasting some seven weeks from the onset of fever to death, would also be a little more acute than any Hodgkin's disease I have seen. Even the fulminating type usually lasts three months.

The other condition I have listed here is one of the reticuloendothelial diseases. I have mentioned acute monoblastic leukemia, which I think belongs in that general family. There are quite a number of reticuloendothelial abnormalities, as you know. Did he have a reticuloendotheliosis which destroyed his marrow? Again reticuloendotheliosis of any kind except acute monoblastic leukemia usually does not show the fulminant course that this individual had.

So as I look over all possibilities which would be likely to explain this man's death I come back again to the fact that he had been drinking this tar remover and I think the condition that would best fit the course of this man's disease is acute benzol poisoning. In summary then, I would state that my first choice, and really my only choice, of diagnosis would be aplastic anemia caused by acute benzol intoxication. I would put Hodgkin's disease as my second choice, and acute monoblastic leukemia my third choice. However, both diseases seem unlikely for the reasons stated.

Multiple Hemorrhages

Pathologically, this man should show multiple hemorrhages in various tissues because of the low blood platelets, and he ought to show a rather general reticuloendothelial hyperplasia, particularly in the bone marrow, the spleen and lymph nodes, where most of the reticuloendothelial elements are aggregated. I say that because experimental work with benzol poisoning has shown that this drug seems to prevent the reticuloendothelial cells from manufacturing cells which mature into normal blood elements. I think that this patient's bone marrow will be aplastic as far as normal cells are concerned, but will show an increase in reticuloendothelial elements.

I doubt if the autopsy will reveal much infection. This patient was certainly saturated with antibiotics, and we have seen many individuals who die with practically no cells in their blood, but no infection. The patient might have a staphylococcic enteritis, but his protocol does not support that very well. He is probably going to show a toxic hepatitis with degenerative changes in the liver cells. I have no other way to account for his terminal jaundice. As an incidental finding, he may also have some adrenocortical hyperplasia since he received ACTH and most individuals who have been given ACTH show this at surgery or autopsy.

Clinical Diagnosis

1. Fulminating aplastic anemia due to acute benzol intoxication.
2. Generalized reticuloendotheliosis.
3. Toxic hepatitis.
4. Adrenocortical hyperplasia.
5. Possible staphylococcic enterocolitis.

Pathological Diagnosis

1. Toxic necrosis of bone marrow.
   (a) Pancytopenia.
   (b) Hemorrhagic diathesis.
2. Secondary reticulum cell hyperplasia.
3. Adrenocortical hyperplasia.
4. Jaundice.

Pathological Discussion

DR. VON HAAM: At autopsy the patient appeared well developed, well nourished and considerably jaundiced. The peritoneal cavity contained 1500 cc. of yellowish, cloudy fluid. Both pleural cavities contained approximately 900 cc. of straw-colored fluid. The heart was of normal size and showed no evidence of gross pathologic change. The lungs appeared partially collapsed and hemorrhagic. The spleen weighed 360 Gm.; it was firm and dark red. The liver appeared grossly normal. The mesenteric lymph nodes were moderately enlarged and firm. The gastrointestinal tract showed extensive submucosal hemorrhages, most noteworthy in the stomach. The adrenals were increased in size and weight and showed a bright yellow cortical tissue. The remaining organs including the brain appeared normal on gross examination.

Microscopic Examination

Microscopic examination of the heart showed extensive reticulocyte proliferation throughout the heart muscle resembling some type of chronic myocarditis. The heart muscle also showed small areas of necrosis, and there were numerous fine petechiae throughout the myocardium. Examination of the lungs showed extensive alveolar hemorrhages and no evidence of any secondary infection. The lung tissue appeared quite atelectatic and the bronchi were filled with a hemorrhagic exudate, suggesting anoxia as the final event.

Examination of the spleen and lymph nodes showed an extensive reticulum cell hyperplasia without much evidence of active hypersplenism. The spleen also did not show extramedullary hematopoiesis. Similar reticulum cell hyperplasia was observed in the liver. The liver cells, however, appeared normal and there was no evidence of any degenerative lesion. Examination of the adrenal glands confirmed the gross diagnosis of

adrenocortical hyperplasia. Examination of the bone marrow showed nearly complete necrosis of the areas which were examined. In some sections a few islands of preserved bone marrow remained. There was a focal reticulum cell hyperplasia which was far less than that found in other organs. Examination of the kidneys revealed only parenchymal hemorrhage.

In summary then, we can state that the autopsy findings confirmed almost verbatim Dr. Wiseman's prediction. The only clinical diagnosis which could not be substantiated was that of toxic hepatitis, and I believe that his jaundice was not due to liver injury but to hemolysis of his extravasated blood cells and the transfused blood. We found no evidence of bile stagnation in the liver and his liver function was probably not impaired.

The severe reticulum cell hyperplasia was so impressive that the idea of reticuloendotheliosis was entertained. However, the changes in the bone did not support such diagnosis, and I am in full agreement with Dr. Wiseman that the reticulum cell hyperplasia was secondary to his bone marrow lesion. Complete lack of extramedullary hematopoiesis also agrees with the point he made with regard to the paralyzing effect of benzol upon the maturation process of reticulum cells in benzol poisoning. The absence of any terminal infection in the lungs and in the gastrointestinal tract is remarkable and speaks for the effectiveness of modern antibiotic therapy.

The patient died from the effect of anoxia produced by his anemia, aggravated by severe atelectasis and hemorrhages in his lungs. Most of the accumulation of fluid in the pleural cavities must have been a terminal process since it was not present on x-ray examination shortly before his death.

Cholecystectomy Performed During The Post-Optimal Period

Many surgical writers favor operative intervention within the first 12 to 48 hours following the onset of acute disease. Cholecystectomy is not a procedure to be undertaken lightly in any instance, and the literature warns the unwary about vascular and ductal anomalies of the gallbladder and common duct, and contains treatises on reconstruction of the damaged common duct.

For surgeons who undertake surgery for the relief of acute gallbladder disease, such warnings must be emphasized even more forcefully, and they must be cautioned about the increased hazards of trauma to this area.—J. K. MacGregor, M. D., Mason City: *J. Iowa M. Soc.,* 48:502, Sept., 1958.

Many Factors May Be Accountable in Development of Periarteritis

Previously Rich and his co-workers studied the effects of cortisone and ACTH in rabbits that were sensitized to horse serum and reported a striking decrease in incidence of vascular lesions. Bagenstoss reported temporary relief in human periarteritis nodosa treated with cortisone. Apparently hormonal influences are important in the etiology of both periarteritis and hypertension, but several essential points are as yet unsupported by experimental proof.

Thus hormonal factors as evidenced by the above discussion, hypersensitivity first related by Rich and Gregory and illustrated by this experiment, and hypertension, usually a result of some degree of interference with the blood supply of one or both kidneys, all seem to play a role in the development of periarteritis. Figure 2 (in this report) exemplifies how each of the above processes may enhance the production of fibrinoid change and are manifest as different yet apparently similar arterial lesions.

In individual cases, experimental or clinical, the evidence may appear to point to one predominant agent as the most probable etiology. However, once the fibrinoid change, which may well be the common denominator in the whole process, has developed, many factors may then accentuate the vascular damage.—Ben D. McCallister, M. D., Honolulu: *J. Kansas M. Soc.,* 59:141, April, 1958.

Bedside Considerations of Heart Failure

When the physician is confronted with some abnormality, he naturally seeks one isolated cause to explain the defect. This is a fine approach except that it will rarely be rewarded with a simple answer. The word "pneumonia" once served for the explanation of an illness. It is obviously inadequate for it tells one nothing of the nature of the invading organism, the probable immune responses of the individual or the responses to be expected from antibiotics. The search goes on for a finer and finer end point of one cause, and yet the ramifications of contributing influences become broader and broader rather than narrower. The same is true of heart failue.

Congestive heart failure describes a symptom complex due to faulty heart function. The various manifestations relate to errors in function of organs of the body distant from the heart. Thus, digestive, cerebral, renal, and steroid derangements all appear.—EDITORIAL: *J. Florida M. A.*, 45:307, September, 1958.

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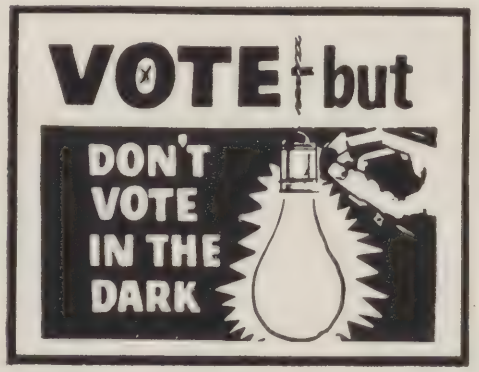
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See you at the polls!

IF You Want a Voice In Your Government, Vote on November 4 — Get Others in Your Neighborhood To Vote.

Physicians Should Ask the Officers and Legislative Chairman of Their County Medical Society for the Facts about the Candidates.



Medicare Coverage Slashed . . .

Drastic Curtailment Is Effective October 1 in Keeping with Limited Congressional Appropriations; Reductions in Program Are Explained

DRASTIC curtailment of the Military Dependents Medical Care Program (Medicare) became effective October 1.

This resulted from Congressional action limiting expenditures for the Medicare Program for the current fiscal year to $72,346,000. Expenditures for Medicare have been at the rate of about $90-million. Also, Congress ordered the Defense Department to make optimum utilization of uniformed services medical facilities.

Mutual of Omaha has been designated as administrator of the medical part of the program in Ohio for this current year. Blue Cross will handle hospital administrative details.

The following explanation of how the Medicare Program will operate under the restrictions is based on an official bulletin issued by the Office of Dependents Medical Care, Washington, on August 29.

Spouses and Children Residing Apart from Sponsors

Spouses and children residing apart from sponsor will continue to be allowed selection of either uniformed services medical facilities or civilian medical sources for care authorized under the program.

When DA Form 1863 shows "Residing Apart from Sponsor—yes," in Item 4 of the claim form, the designation of this fact on the claim form by the person signing Item 14 will be sufficient, and authorized care rendered will be payable provided that the person or entity providing the care has no actual knowledge to the contrary.

Restrictions on Spouses and Children Residing with Sponsors

Spouses and children residing with sponsor will be required to utilize uniformed services medical facilities if available and adequate as determined by the commander of the medical facility. When uniformed services medical facilities are not available, a PERMIT will be furnished such dependents by the appropriate commander. This PERMIT will entitle them to receive authorized care from civilian sources at Government expense if such care is authorized under Public Law 569 and the Joint Directive, as amended. A summary of changes in the scope of authorized care is set forth below.

Action Which Must Be Taken By Physicians and Hospitals

Effective October 1, 1958, it will be necessary for physicians and hospitals rendering care to eligible dependents to take the following actions in order to insure payment of their claims for authorized care rendered:

a. When DA Form 1863 shows "Residing Apart from Sponsor—No," to allow payment for authorized care, a PERMIT is required as noted above **(a copy of which must be attached to the original copy of the attending physician's and the hospital's claim form), except** in the following circumstances:

(1) When spouse or child residing with sponsor is hospitalized for care authorized under the program in a bona fide acute emergency, e. g., serious injury following an accident or illness of sudden onset requiring immediate treatment at the nearest available medical facility to preserve life, or to prevent undue suffering, **a statement by the attending physician on the DA Form 1863, or attachment thereto, in lieu of a PERMIT, is required,** stating, "This case was a bona fide acute emergency."

(2) Where a spouse or child is residing with sponsor, but is away from the area of the sponsor's household on a trip, care authorized under the Program may be provided from civilian sources without a PERMIT. The statement "On Trip" in Item 3 or 4 of the DA Form 1863, by the person signing Item 14, will suffice, provided the person or entity providing the care has no actual knowledge to the contrary.

(3) A maternity case (residing with sponsor) under the care of a civilian physician on or before October 1, 1958, may be continued by that physician provided the patient has reached the second trimester of pregnancy on or before that date. In these cases a statement by the attending physician on the DA Form 1863, (or attachment thereto) will be submitted by the physician and the hospital to the effect that the patient was under his care on or before October 1, 1958, and that her pregnancy

had reached the second trimester on or before that date. This statement will suffice to authorize this care for payment without a PERMIT **and will apply only to maternity cases where the wife resides with her sponsor.** No restriction as to fredom of choice has been placed on those eligible dependents who reside apart from sponsor.

(4) Spouses and children **residing with sponsor** admitted to a hospital for authorized care prior to midnight, September 30, 1958, and whose hospital care resulting from this admission extends beyond September 30, 1958, will not be required to provide a PERMIT for that admission to the hospital. Nevertheless, the date of admission shown by the hospital on all claim forms submitted involving care of an eligible dependent must indicate that the admission occurred prior to October 1, 1958.

(5) Spouses and children **residing with a sponsor** who are receiving authorized care from a physician and who are admitted to a civilian hospital prior to midnight, September 30, 1958, will be authorized care by a civilian physician without a PERMIT, provided the physician shows the date of admission to a civilian hospital on his claim form, and this date is prior to October 1, 1958.

Here Is Way Permits Should Be Handled

PERMITS, where required, must be attached to the original copies of DA Form 1863 on claims submitted by attending physicians **and** hospitals. Claims submitted by other than attending physicians or hospitals, e. g., Assistant Surgeon, Radiologist, Pathologist, Anesthesiologist, Dentist (when not in capacity of the attending physician), Consultant, Physiatrist, Private Duty Nurse, Anesthetist, and Physical Therapist, will be authorized for payment without a PERMIT. However, claim form (DA Form 1863) must contain a statement by the person executing the certification in Item 14 that a PERMIT was furnished to the attending physician (identified by name) and/or to the hospital (identified by name).

Care No Longer Payable Under the Dependents' Medical Care Program

In order to comply with budgetary limitations placed on the Dependents' Medical Care Program by the Congress for Fiscal Year 1959, rigid restrictions are immediately required. Therefore, it is necessary to curtail certain care and services currently authorized by the Joint Directive under discretionary authority vested in the Secretary of Defense by Public Law 569. **Effective October 1, 1958,** and in order to implement the above, the Joint Directive has been amended so that **the following care and services, if commenced on or after that date, will not be payable by the Government** under the Dependents' Medical Care Program:

a. Treatment of fractures, dislocations, lacerations and other wounds on an outpatient basis, previously authorized.

b. The Termination Visit. This refers to payment of a referring physician who terminates his care prior to, or upon hospitalization of, the patient. This was previously authorized and was formerly payable under Code 0042 in recently negotiated Medicare Manual and Schedule of Allowances, and Code 0011 in the original Schedule of Allowances for Physicians' Fees.

c. Outpatient pre- and post-surgical tests and procedures. These were formerly authorized in an amount of $75.00 before hospitalization, and $50.00 after hospitalization.

d. Neonatal Visits. Formerly authorized on an outpatient basis not to exceed two visits during the first 60 days, except that in the case of home or office deliveries necessary infant care may be provided on an outpatient basis during a period not to exceed 10 days following the date of delivery. Payment for this service would be in accordance with Code 0022 in the current Medicare Manual and Schedule of Allowances. The in-hospital part of care of the newborn is still allowable as part of complete maternity care, and is payable under Code 0022 in the current Medicare Manual and Schedule of Allowances, and Codes 0002 and/or

Medicare Figures For Ohio For Last Fiscal Year

Here is a breakdown on Medicare figures for Ohio for the period July 1, 1957 to June 30, 1958, taken from records of the Medicare office, Washington:

Total medical claims in Ohio, 16,955; amount $1,308,755; percentage of national as to claims filed 2.83; as to amount paid, 2.90.

Total hospital claims in Ohio, 9,980; amount $1,140,670; percentage of national, as to claims filed, 2.82; as to amount paid, 2.88.

Total amount medical and hospital claims in Ohio, $2,463,570; percentage of national, 2.89.

Total medical hospital claims filed in the nation, 951,894; the total amount paid, $84,738,560.

0010 in the original Schedule of Allowances for Physicians' Fees.

e. The treatment of acute emotional disorders. This was formerly authorized, when an acute emergency existed. Except, however, care of an acute emotional disorder may be furnished to a spouse or child, if required, during the period of hospitalization of that spouse or child for a condition that does qualify as authorized care.

f. Elective surgery.

"Elective Surgery" has been defined below and does not constitute authorized care:

> "Medical or surgical care that is desired or requested by the patient which in the opinion of the cognizant medical authority can be planned, subsequently scheduled, and effectively treated at a later date without detriment to the patient, e. g., diagnostic surveys, cosmetic surgery, reconstructive surgery, tonsillectomies, uncomplicated hernias, and interval appendectomies."

Surgical Procedures Authorized For Payment

Surgical Emergencies Requiring Hospitalization. Bona fide surgical emergencies, which cannot be handled on an outpatient basis, will continue to be honored for payment under the Program. Such patients will necessarily be acutely ill and in need of **immediate** hospitalization and treatment. Examples include perforated duodenal ulcer, hemorrhage with shock, bowel obstruction, and similar recognized emergencies.

Acute Surgical Conditions. It is well recognized that many acute surgical conditions develop which, while requiring prompt treatment in a hospital, are not considered emergencies under the Program. Under such circumstances the patient is acutely ill and must receive treatment without delay as time will not permit the patient to anticipate or plan for the care required. The procedure required for the treatment will of necessity be carried out at the earliest practicable time compatible with sound surgical judgment and the proper preparation of the patient for surgery. The spirit of this requirement is that the ill patient is in clinical need of hospitalization without delay with a view to surgical correction of the basic condition. Examples are acute appendicitis, empyema of the gall bladder, twisted ovarian cyst, strangulated hernia, pelvic abscess, and renal or ureteral calculi with colic. When the charge physician so indicates that an acute requirement existed, payment will be authorized. Suspected or proven malignancy, requiring hospitalization, will be payable only if the case qualifies under this or the preceding sub-paragraph.

Injuries Requiring Hospitalization. Injuries of such clinical severity as to require hospitalization will continue to be payable. Hospitalization is authorized only for the treatment of the acute phase. Readmission for treatment of chronic stages or sequelae of injury would not be payable unless an acute medical or an acute surgical requirement is shown, such as, osteomyelitis, with acute exacerbation.

Surgical Procedures Not Authorized For Payment

Elective surgery described above which, from a practical viewpoint, permits the patient and the physician to plan for the surgery required, is not authorized for payment under the program. Hence, a great many surgical procedures payable in the past are not now authorized unless, due to unusual circumstances. Examples are Tonsillectomy, Dilation and Curettage, Hysterectomy (Routine), Ligation of Fallopian Tube, Heart Surgery, Submucus Resection, Rhinoplasty, and Reconstructive Orthopedic and Plastic Procedures.

No Change Made in Acute Medical Conditions and Dental Care

The provisions pertaining to the treatment of acute medical conditions remain unchanged. However, the admission of patients not actuely ill for diagnostic surveys will not be payable.

The provisions pertaining to dental care remain unchanged. However, adjunctive dental care is now payable only when it is an integral and necessary part of surgical or medical care now authorized. It must be clearly shown that the dental care furnished was required for the proper treatment of the basic medical or surgical condition for which the patient was hospitalized.

Treatment Commenced Before Oct. 1, 1958 Where Care Has Been Deleted

Hospitalized Patients. A patient will be deemed to have commenced receiving such care if admitted to the hospital prior to midnight on September 30, 1958. Care is authorized during that period of hospitalization if the claim form shows an admission date earlier than October 1, 1958. The care referred to here includes the termination visit and outpatient pre- and post-surgical tests and procedures associated with this admission.

The Two Neonatal Visits previously authorized will be payable, if the birth occurs prior to midnight September 30, 1958, and if the physician's claim form contains a statement to that effect.

Outpatient Injuries will be deemed to have commenced prior to midnight September 30, 1958, and, therefore, payable if the patient contacted a source of care prior to that time, and if the source of care so states on the claim form.

Group Life Plan Is Now in Effect; 1234 Are Enrolled; Additional Chance Offered on District Basis

THE Group Life Insurance Plan of the Ohio State Medical Association became effective September 1. As of September 9, 1234 members and employees of members were covered for the basic insurance of $10,000 for which they had subscribed.

Of that number 365 members subscribed for additional $10,000 coverage for which evidence of insurability had to be submitted. The additional insurance taken by the 365 members will become effective as soon as the Home Office of Union Central Life Insurance Co. has processed the applications and given approval. The total amount of basic insurance in force as of September 1 was $8,240,250.

The state-wide enrollment was terminated on September 18. In the near future, enrollment will be re-opened in one of the Councilor Districts for a period of 60 days during which those who have not enrolled will be able to enroll without evidence of insurability, providing at least 50 per cent of the members in the District enroll, counting those who enrolled during the state-wide enrollment. All Councilor Districts will be handled in this way eventually.

Board of Abdominal Surgery Not AMA - Approved

During the past several weeks many Ohio physicians have received an invitation, originating at Boston, to become an affiliate of an organization calling itself the American Board of Abdominal Surgery. In response to inquiries, the Columbus Office of the Ohio State Medical Association requested information on the organization from the American Medical Association. Following is a statement issued in Mid-August by the Council on Medical Education and Hospitals of the AMA:

"The Council on Medical Education and Hospitals has received many inquiries from individuals who have been invited to submit applications for the Founders Group of the American Board of Abdominal Surgery. The inquirers have been concerned as to whether the American Board of Abdominal Surgery is approved by the Council on Medical Education and Hospitals.

"Several years ago the Council was delegated the responsibility to act for the American Medical Association to grant approval to specialty boards which met appropriate requirements and standards. The Council on Medical Education and Hospitals continues to fulfill this function, assisted by the Advisory Board for Medical Specialties, which is composed of representatives from each of the approved specialty boards.

"The American Board of Abdominal Surgery has not sought recognition from either the Council on Medical Education and Hospitals or the Advisory Board for Medical Specialties. It is, therefore, not approved by either of these groups."

UMW Fund Expended $58,135,000 On Health Benefits Last Year

United Mine Workers' Welfare and Retirement Fund spent $138,501,681 in fiscal year that ended June 30, 1958, of which $58,135,684 went for medical, rehabilitation and hospitalization benefits. The detailed accounting is given in Fund's latest annual report. Hospital days totaled 1,458,385, with 85,426 beneficiaries. Inpatient physicians' visits totaled 1,311,088, plus 969,801 office and outpatient clinic consultations.

In the previous year, $59,584,594 was spent in this field on 1,631,144 days of hospitalization, 1,556,111 visits by physicians to hospitalized patients and 885,944 consultations in clinics and offices. There were 93,679 beneficiaries.

The report attributes dollar savings to policy of restricting payments to "physicians and hospitals whose services are determined by the Fund's Medical, Health and Hospital Service to be necessary and essential." The report says Fund's experience indicates "great majority of physicians understand fully the Trust Fund's positon and desire to cooperate with the Fund in providing good medical care and preventing waste of Fund resources."

Diseases of the Chest

The Council on Postgraduate Medical Education of the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, will present the following Postgraduate Courses this fall: Clinical Cardiopulmonary Physiology, Edgewater Beach Hotel, Chicago, October 13-17. Diseases of the Chest, Park-Sheraton Hotel, New York City, November 10-14.

AMEF Merits Physician Support . . .

Aid from the Medical Profession Will Be Solicited in Fall Campaign To Promote Medical Education; AMEF Chairman for Each County Named

OHIO physicians again have an opportunity this Fall to support the Nation's medical schools by contributing to the American Medical Education Foundation.

Dr. Merrill D. Prugh, Dayton, is chairman of the Ohio AMEF committee, which is composed of the 11 District Councilors of the Ohio State Medical Association.

In 1951 two non-profit organizations were formed to encourage private support of the medical schools. The American Medical Education Foundation was established by the American Medical Association to raise funds from the medical profession. The National Fund for Medical Education was organized to solicit financial support from business and industry.



M. D. Prugh, M. D.

Since 1951 a total of $17,900,869 has been distributed to the medical schools by the two organizations. Of that amount, $6,741,465 came from physicians and medical organizations. In addition, physicians contribute approximately $1,500,000 per year directly to their own schools.

Allotments to the medical schools have been used for such worthy purposes as: purchase of teaching equipment; improvement of faculty salaries, particularly for younger staff members and improvement of library facilities.

If he wishes, the AMEF donor may designate his gift for his own Alma Mater or any other school in which he is particularly interested. Contributions which are not specifically earmarked by the donor are pooled and distributed among all the schools on the following basis: a uniform gift for each school plus an additional award depending on the number of students enrolled.

During 1957, a total of 44,155 contributors gave $984,884.40 to AMEF. In addition, 50,364 physicians gave a total of $3,020,600.43 directly to the Alumni Funds of their own schools, making a grand total of $4,005,484.83 contributed by physicians to the cause of medical education during the year.

Ohio Record High

Ohio's AMEF total for 1957 was a record high of $33,141.87 from 717 contributors. Included in that amount was $10,682.34 raised through various projects by the Woman's Auxiliaries throughout the state, an accomplishment for which the auxiliaries received national recognition. Ohio physicians numbering 3,646 also contributed $132,566.56 directly to the Alumni Funds of medical schools. The grand total for Ohio in 1957 was $165,708.43 from 4,363 donors.

Realizing the importance of keeping the Nation's medical schools independent and financially solvent, Dr. Prugh, the members of the 1958 AMEF state committee and the local chairmen are hopeful that many more Ohio physicians will join the ranks of their more than 4,000 colleagues who made gifts for medical education last year either through AMEF or directly to medical schools.

A local chairman has been appointed for each county medical society to follow-up the mail solicitations which will begin on or about October 1. The county chairmen are:

First District

ADAMS—Herman P. Hyder, Bentonville
BROWN—Leslie Hampton, Jr., Sardinia
BUTLER—Gilbert P. Wagoner, Middletown
CLERMONT—John M. Coleman, Loveland
CLINTON—Edmond K. Yantes, Wilmington
HAMILTON—Charles A. Sebastian, Cincinnati
HIGHLAND—Leland Dale McBride, Hillsboro
WARREN—D. Paul Ward, Pleasant Plain

Second District

CHAMPAIGN—Arthur B. Ream, Mechanicsburg
CLARK—Lillian M. Posch, Springfield
DARKE—Gilbert E. Sayle, Greenville
GREENE—Harvey B. McClellan, Xenia
MIAMI—William T. Wilkins, Jr., Piqua
MONTGOMERY—Kenneth D. Arn, Dayton
PREBLE—A. L. Ross, West Alexandria
SHELBY—John H. Kerrigan, Sidney

Third District

ALLEN—F. Miles Flickinger, Lima
AUGLAIZE—Elizabeth Y. Kuffner, St. Marys
CRAWFORD—William C. Manthey, Galion
HANCOCK—Harry J. Miller, McComb
HARDIN—Robert H. Zeis, Kenton
LOGAN—Charles H. Thompson, West Mansfield
MARION—Frederick G. Smith, Marion
MERCER—Edgar J. Wilike, Maria Stein
SENECA—Avery D. Powell, Tiffin
VAN WERT—S. A. Edwards, Van Wert
WYANDOT—F. M. Smith, Sycamore

Fourth District

DEFIANCE—James E. Cameron, Defiance
FULTON—Clarence F. Murbach, Archbold
HENRY—Richard L. Gilson, Napoleon
LUCAS—Sam H. Patterson, Toledo
OTTAWA—Cyrus R. Wood, Port Clinton
PAULDING—John H. Schaefer, Paulding
PUTNAM—David A. Barr, Lima
SANDUSKY—M. M. Riddell, Fremont
WILLIAMS—Russell K. Ameter, Bryan
WOOD—Halford E. Whitacre, Bowling Green

Fifth District

ASHTABULA—Alfred A. DeCato, Ashtabula
CUYAHOGA—Donald B. Cameron, Cleveland
GEAUGA—Alton W. Behm, Chardon
LAKE—Morris G. Carmody, Painesville

Sixth District

COLUMBIANA—A. J. Knapp, East Liverpool
MAHONING—Harry A. Smith, Youngstown
PORTAGE—John S. Deyell, Ravenna
STARK—Blanchard V. Antes, Canton
SUMMIT—James C. Oberholtz, Akron
TRUMBULL—Densmore Thomas, Warren

Seventh District

BELMONT—Fred Wm. Cook, Jr., Martins Ferry
CARROLL—Joseph D. Stires, Malvern
COSHOCTON—Gerald A. Foster, Coshocton
HARRISON—Dwight C. Pettay, Cadiz
JEFFERSON—M. H. Rosenblum, Steubenville
MONROE—Byron Gillespie, Woodsfield
TUSCARAWAS—Samuel H. Winston, Dover

Eighth District

ATHENS—Robert E. Main, Athens
FAIRFIELD—Kenneth A. Gaines, Lancaster
GUERNSEY—F. Gordon Lawyer, Cambridge
LICKING—Warren N. Koontz, Newark
MORGAN—Henry Bachman, Malta
MUSKINGUM—Walter K. Chess, New Concord
NOBLE—E. G. Ditch, Caldwell
PERRY—Ralph E. Herenden, Jr., New Lexington
WASHINGTON—W. D. Turner, Marietta

Ninth District

GALLIA—Marcus J. Magnussen, Gallipolis
HOCKING—George B. Watson, Adelphi
JACKSON—Garrett B. Ackerman, Wellston
LAWRENCE—George Newton Spears, Ironton
MEIGS—Charles J. Mullen, Pomeroy
PIKE—Mack E. Moore, Piketon
SCIOTO—William J. Hartlage, Sciotoville
VINTON—H. D. Chamberlain, McArthur

Tenth District

DELAWARE—James G. Parker, Delaware
FAYETTE—Frank C. King, Washington C. H.
FRANKLIN—L. Chandler Roettig, Columbus
KNOX—Henry T. Lapp, Mt. Vernon
MADISON—Paul G. H. Wolber, London
MORROW—Andrew Maciurak, Cardington
PICKAWAY—Walter F. Heine, Circleville
ROSS—F. W. Nusbaum, Chillicothe
UNION—James W. Sampsel, Marysville

Eleventh District

ASHLAND—John M. Strait, Ashland
ERIE—Henry W. Lehrer, Sandusky
HOLMES—Neven P. Stauffer, Millersburg
HURON—George F. Linn, Norwalk
LORAIN—Lewis B. Stephan, Lorain
MEDINA—R. F. Fasoli, Brunswick
RICHLAND—Melvin Christian, Mansfield
WAYNE—Robert E. Schulz, Wooster

Do You Know? . . .

George H. Saville, Director of Public Relations, Ohio State Medical Association, has been named chairman of the Advisory Committee to the Department of Public Relations of the American Medical Association. The committee, appointed by the Board of Trustees of the A. M. A., consists of nine medical society executives from throughout the country.

* * *

Dr. Ross M. Knoble, Sandusky, has been named chief surgeon of the Ohio Soldiers' and Sailors' Home in Sandusky. He succeeds the late Dr. Fernand J. Leblicq in that post.

* * *

Dr. Carl J. Wiggers, Cleveland, professor emeritus of physiology at Western Reserve, recently was conferred the honorary doctor of science degree by Ohio State University.

Outstanding Faculty Announced For Sixth District PG Day

Physicians of the Sixth Councilor District have received direct mail information about the Postgraduate Day scheduled at the Sheraton-Mayflower Hotel, Akron, on Wednesday, October 22. Physicians outside of the district are invited to write for topics and other details to: The Summit County Medical Society, Second National Building, Akron. Advance Registration is $10.

Registration opens at 8:00 a. m. with the program starting at 9:30. The program has been approved by the American Academy of General Practice for eight hours credit.

The faculty has been announced as follows:

Surgery — Dr. George Block, University of Michigan; Dr. Richard B. Cattell, Lahey Clinic; Dr. Deryl Hart, Duke University; Dr. Paul Hodgson, University of Michigan; Dr. William Regan, University of Michigan.

Medicine—Dr. J. Earle Estes, Mayo Clinic; Dr. William Jefferies, Western Reserve University; Dr. R. G. Siekert, Mayo Clinc; Dr. Joseph Vanderveer, University of Pennsylvania.

Pediatrics—Dr. John Caffey, Columbia Presbyterian Medical Center; Dr. Edward A. Mortimer, Jr., Western Reserve University; Dr. G. Mason Sones, Cleveland Clinic; Dr. Mitchell Rubin, University of Buffalo.

Obstetrics & Gynecology—Dr. M. Edward Davis, University of Chicago; Dr. Allan F. Guttmacher, Mt. Sinai Hospital, New York; Dr. John G. Masterson, State University of New York; Dr. Clyde L. Randall, University of Buffalo; Dr. Frederick Zuspan, Western Reserve University.

Hospital Needs of Aged . . .

Policy on Ways to Meet This Question Is Adopted by American Hospital Association at Recent Annual Session in Chicago; Steps Are Outlined

THE House of Delegates of the American Hospital Association, meeting in Chicago in August, adopted a statement of policy with respect to meeting the hospital needs of the aged. The statement, which supersedes all previous actions taken by the association, follows:

1. The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care.

2. It believes that federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing hospital care even for the retired aged.

3. It believes that all possible solutions must be vigorously explored, including methods by which the dangers inherent in the Social Security approach can be avoided.

4. It believes that every effort should be made to meet the hospital needs of the retired aged principally through mechanisms utilizing existing systems of voluntary prepayment. However, it is conceivable that the use of Social Security to provide the mechanisms to assist in the solution of the problem of financing these needs may be necessary ultimately.

5. It believes that any legislation developed to provide for government participation to meet the hospital needs of the retired aged should be so devised as to strengthen the voluntary prepayment systems, and should conform to the following principles:

a. Legislation designed to provide for the hospital needs of the retired aged should provide essential hospital services and should exclude custodial care provided for nonmedical reasons.

b. Government participation should be restricted to persons over 65 who are not regularly and substantially employed. The voluntary prepayment system provides a satisfactory mechanism for the coverage of other persons, regardless of age.

c. Any program in which the federal government participates to meet the hospital needs of the nonindigent aged should emphasize individual responsibility and make the application of a means test unnecessary for obtaining benefits.

d. Such a program should be based on the service benefit principle and should provide benefits sufficiently comprehensive to remove the major economic barriers to hospital care for the retired aged.

e. Such a program should make benefits available through nonprofit prepayment plans.

f. Hospitals should be paid fully for the cost of care rendered.

g. Such a program should not provide services in facilities operated by the federal government.

h. Such a program should provide reasonable criteria to determine the eligibility of hospitals to participate, but the federal government should be precluded from interfering in the administration and operation of hospitals providing the services.

i. Such a program should maintain the free choice of doctor and hospital by the recipient.

j. Such a program should permit and encourage continuous adaptation to new knowledge in the provision of services.

Another Movie In Medico-Legal Series Now Available

The third film in the series being sponsored by the Wm. S. Merrell Company, and prepared jointly by the American Medical Association and the American Bar Association, had its premier showing at the Palace Hotel in San Francisco on June 25 during the AMA meeting. It is entitled "The Man Who Didn't Walk" and it concerns itself with the condition known as traumatic neurosis. It is of particular interest to both physicians and lawyers because traumatic neurosis, though not universally accepted as a clinical entity, is, nevertheless, frequently used today by claims-seeking plaintiffs as an explanation of the plaintiff's disability.

The film points up the fact that it is the responsibility of both physician and attorney to conduct complete examinations, to collaborate in pre-trial conferences, and to present testimony to help the jury decide this often baffling and puzzling problem of law and medicine.

If you want this film to be shown at one of your county society meetings, have your program chairman contact the AMA film library, 535 North Dearborn Street, Chicago 10, Illinois.

Review of What Congress Did . . .

Unusual Number of Bills Affecting Medicine or Health Taken Up by 85th Congress; Prospects on Major Issues for the Next Session Are Outlined

FOLLOWING is a review of the first and second sessions of the 85th United States Congress which adjourned recently, prepared by the Washington Office of the American Medical Association.

The second session of the 85th Congress, beset with space age and other problems and operating in the charged atmosphere of an election year, found time to take up an unusual number of bills of interest to medicine. It passed more than a dozen. Just as notable were two bills that did not pass.

While the Forand bill for a hospitalization program under social security failed to clear the House Ways and Means Committee, the committee did order the Department of Health, Education, and Welfare to make a thorough study of the problem of financing medical care of the aged, with emphasis on use of social security. Because the report is due by next February 1, the basic issue is almost certain to come to the front again early in the new Congress.

Another major issue left hanging was that of tax-deferment on annuities for the self-employed—the Keogh bill. It went through the House by an overwhelming vote and won the support of 32 Senators, two factors that suggest it may be enacted next year. Following are reviews of the provisions of all major health bills enacted in both sessions of the 85th Congress, and comments on prospects for the more important measures that were left by the wayside.

Medicare Appropriations

Congress took a long look at the medicare program, now nearing its second anniversary, and decided that the civilian phase of the program had to be curtailed in favor of greater use of military facilities. **(See Pages 1326-1328 for detailed Medicare story.)**

Social Security Amendments

As it has done every election year since 1950, Congress again amended the Social Security Act. It increased Old Age, Survivors and Disability Insurance benefits by 7 per cent, in response to demands that benefits keep pace with the cost of living. It provided an additional $197 million for public assistance recipients, and gave states greater flexibility in use of federal funds for financing the medical care of the aged, blind, the disabled and dependent children. To finance the liberalizations, the law increases the taxable base from $4200 to $4800 of gross employment earnings and raises the tax in 1959 from 2¼ per cent to 2½ per cent for the employer and employee, and from 3⅜ per cent to 3¾ per cent for the self-employed. Additional increases are scheduled for 1960, 1963, 1966 and 1969. By 1969, the self-employed will be paying 6¾ per cent of earnings.

Congress left the door ajar for consideration by the next Congress of bills using the social security system to provide hospital and medical care for OASDI beneficiaries. An articulate minority wanted this enacted this year via the proposal of Rep. Aime Forand (D., R. I.), but Congress decided against it. However, the House Ways and Means Committee directed the administration to make a study and report by next February on the various possibilities for financing medical care for the aged, with particular emphasis on the possible practicability of increasing OASDI taxes and using the money to purchase health insurance on retirement. **The AMA took a strong stand against using the social security system to provide such care, viewing it as a beginning of national compulsory health insurance.**

White House Conference on Aging

The President is instructed to call a White House Conference on Aging in January, 1961, by a measure passed late in the session. This national meeting will bring together federal, state and local leaders working in the field of aging. A series of state-organized meetings would precede the 1961 conference. To help the states finance these meetings, the law provides up to $15,000 a state with a minimum of $5,000. The AMA gave this legislation its full support.

Chemical Additives in Food

In an 11th hour action, the Senate passed a House-approved bill on the last day of the session which prohibits use of chemical additives in foods until their pre-testing has been approved by the Food and Drug Administration.

Health Appropriations

In response to appeals from a number of sources, the 85th Congress set a new high in

money voted for the Department of Health, Education, and Welfare, particularly for the U. S. Public Health Service. The latter now is spending at the rate of close to three quarters of a billion dollars a year. Last year PHS received from Congress approximately $562 million; this year's total is $745,747,000. Research money for the seven institutes was increased nearly 40 per cent over last year, while the Hill-Burton hospital construction program received a boost of close to 55 per cent. If one is to judge from a recent study group of HEW, the peak of spending in the health field hasn't yet been reached. Congress also voted $6.9 million for the long-sought new quarters for the National Library of Medicine.

Hill-Burton Amendments

Because a full year's notice is deemed necessary in future planning, Congress voted a 5-year extension of the Hill-Burton hospital construction program. The act otherwise would expire next June. In a separate action, Congress amended the act to permit for the first time Hill-Burton loans at the same rate of interest the government pays for its own borrowing. Under the loan act, an applicant would have to comply with all H-B regulations, the same as regular H-B applicants.

Defense Reorganization

At the prodding of the House Armed Services Committee, the Defense Department is finally reorganizing. The number of Assistant Secretaries of Defense, which Congress felt had grown too large, was trimmed back by one. Defense Secretary Neil McElroy has informed Dr. Frank S. Berry, Assistant Secretary of Defense for Health and Medical Affairs, that the latter's post will not be abolished under the forthcoming reorganization of the Defense Department, which had been feared. The decision has the concurrence of the President. The American Medical Association had worked to save the post.

Public Health School Grants

Eleven schools of public health were promised a total of $1 million annually in federal grants to assist them in professional training, specialized consultative services and technical assistance with the states. The final act was simply an authorization, which means that funds will not be available until the next Congress acts.

Civil Defense Grants

To bolster sagging state civil defense programs, Congress voted grants to the states for purchase of radiological instruments, personal equipment for state and local civil defense workers and for administrative and personnel expenses. Amounts for the first category would not exceed $35 million; for the second category, not more than $2 million, and for the third, not over $25 million.

Military and VA Pay Schedules

General pay raises for the military included the same increases for physicians in the services. The law also retained the incentive pay schedule for doctors in uniform which has been in effect since 1947. Congress, in a separate act, also approved salary increases for physicians in the Veterans Administration.

Health and Welfare Plans

To correct abuses in health and welfare plans, Congress after considerable debate voted a measure requiring both labor and management health and welfare plans to make annual financial reports to the Secretary of Labor. It exempts plans with fewer than 25 members. Fines as high as $10,000 or five years imprisonment are provided for falsification of reports.

Research Facilities Extension

Two years ago Congress voted a new program of grants to help medical schools and similar facilities doing research in various crippling and killing diseases to construct laboratories and similar buildings or to remodel existing structures. The program was to run for three years, with an annual appropriation of $30 million. With a backlog of applications, the administration sought an extension for another three years. It also asked for a clarification of "multi-purpose" facilities. In the process, the bill was amended in committee so that money would have been available for both research and teaching facilities. This back-door approach to medical school aid later was dropped by the committee, because it was felt that it would jeopardize passage of the simple extension.

Doctor Draft Extension

Under this act passed in the first session, selective service has authority until July 1, 1959, to call certain physicians up to age 35 for military service. Only those doctors with obligations under the regular draft and who have been deferred for any reason may be called. Although the military has been getting enough doctors through new graduates and volunteers, it expects to ask for another extension next year.

Jenkins-Keogh Tax Deferral

The drive to give the self-employed equal treatment with the employed in setting aside tax-deferred sums for retirement plans moved closer

Some Excellent Postgraduate Programs in Various Sections Of the State Are in Prospect for Ohio Physicians

In the September issue of *The Journal* a list of postgraduate courses in various areas of Ohio was published, beginning on page 1190. Some of these programs were scheduled in September and early October. Others are scheduled in the near future and offer excellent opportunities for physicians in those areas. Here is a list of postgraduate courses announced to *The Journal* for the near future:

October 17—Mississippi Valley Trudeau Society Annual Meeting, Dayton (see page 1191, September issue).

October 19—Third Annual Session on Rheumatic Diseases, Ohio State University, Columbus (see page 1193, September issue).

October 22—Sixth District Postgraduate Day, Akron (see page 1331, this issue).

November 1—Columbus Academy of Medicine, Clinic Day, Columbus (see pages 1341-1342, this issue).

November 5—Central Ohio Heart Association, Program on the Radiologist's Role in Cardiology, Columbus, page 1352, this issue.

Series of Postgraduate Courses—Bunts Educational Institute, Cleveland (see page 1193, September issue).

than ever to enactment. A bill passed the House late in July with only a smattering of opposition. But it died in the Senate Finance Committee; a major factor was Treasury Department insistence it would result in a large tax revenue loss. AMA, in concert with the American Thrift Assembly, pressed hard for enactment. New efforts to get the measure passed in the 86th Congress are being planned.

Community Facilities Loans

A bill that started out as an anti-recession measure lost steam as it progressed in Congress. It provided for low-interest loans to states and communities for a wide range of public works, including construction of community hospitals. The measure was voted down in the House after it had passed the Senate.

Medical School Construction Aid

Bills to authorize one-time grants for new and existing medical schools to build class-rooms were pending in both House and Senate at adjournment. No bill was reported to the floor because of (1) concern over the segregation issue, (2) a question of whether the states have exhausted all resources, and (3) a reluctance of some committee members to spend the money now.

Civil Aviation Medicine

Efforts to establish a Civil Air Surgeon with broad authority in civilian air safety failed to pass. But with creation of the Federal Aviation Agency, administration assurances have been given that the needs of aviation medicine will be considered in setting up the new agency. The AMA was a strong supporter of the idea of a Civil Air Surgeon.

Veterans Hospitalization

Late in the session as a windup to lengthy hearings on veterans entitlement to VA hospitalization, the House Veterans Affairs Committee reported out an omnibus hospitalization bill. The measure had as its major objective the opening of some 5,000 additional beds which the committee maintains the Budget Bureau is holding back on. It was reported too late for final action. The AMA testified in favor of a clear spelling out by Congress of veterans entitlement to federal care.

Nursing Home Mortgage Guarantees

Efforts to provide new capital for proprietary and non-proprietary nursing homes through FHA-type mortgage loan guarantees failed of passage. The provision was part of an omnibus housing bill that failed to pass the House after Senate approval. Last-minute efforts to separate the nursing home portion from the bill and have it enacted also failed.

Cancer Symposium

A symposium on carcinoma of the colon and rectum will be presented at the annual scientific session of the American Cancer Society to be held October 20-21 at the Biltmore Hotel, New York City. Physicians on the program include Dr. Rupert B. Turnbull, of Cleveland.

Licensed To Practice in Ohio . . .

Certificates To Practice Medicine and Surgery in This State Are Issued To 348 Graduates of Approved Schools of Medicine Following Examinations

AS A RESULT of examinations given by the State Medical Board in June, certificates to practice medicine and surgery in Ohio were issued to 348 graduates of Schools of Medicine, Dr. H. M. Platter, secretary of the Board, reported.

Also 42 graduates of osteopathic schools were issued certificates to practice osteopathic medicine and surgery.

In the limited practice branches, certificates were issued to the following number of persons: Chiropody, 16; mechanotherapy, 3; chiropractic, 3; massage, 14; and cosmetic therapy, 4.

In the medical examinations two persons tied for highest grade attained and two tied for second place. Following are the high grades awarded: Eugene M. Ross, Cleveland, graduate of Ohio State University College of Medicine, 90.7 per cent; Yvonne M. Mohlman, Mariemont, University of Cincinnati, 90.7 per cent; Myron Moshowitz, Cincinnati, University of Cincinnati, 90.3 per cent; Gordon E. Hanusek, Hamilton, Ohio State University, 90.3 per cent; Luther J. Barth, New Washington, Ohio State University, 90.2 per cent.

Other actions of the Board at its August 14 meeting included that in regard to Dr. Joseph A. Geer. The Board modified the indefinite suspension of Dr. Geer to permit him to obtain employment in state institutions. He is not to engage in private practice and must not violate his parole.

Following is the list of those licensed to practice medicine and surgery, with city of residence and medical school of graduation:

Ohio State University — Herman I. Abromowitz, Dayton; Joseph M. Albrecht, Dayton; Robert F. Amicon, Columbus;

Bernard Barron, Cleveland; Luther J. Barth, New Washington; Merle M. Berman, Columbus; Charles D. Boyle, Warren; Richard E. Brashear, Upper Arlington; Dudley F. Briggs, Frankfort; Jerome H. Brodish, Columbus; Richard W. Brush, Struthers; Jerome Burman, Youngstown; Dolores J. Burton, Dayton; Robert P. Bushell, Columbus; Paul R. Bybee, Cincinnati;

Frederick L. Clegg, Bellefontaine; Eugene J. Colangelo, Columbus; John F. Coleman, Toledo; Frank W. Crowe, Ironton; Jerry D. Culberson, Grove City;

Galen H. Davis, Pennsville; Robert K. Dellinger, Cleveland; James V. Dindot, Grover Hill; Paul A. Ebert, Columbus; Charles R. Everett, North Canton;

Edward Lynn Farnham, Alliance; Robert D. A. Fisher, Cleveland; Harvey M. Friedman, Berea; Robert C. Frymier, Akron; Thomas P. Fuller, Cleveland;

John V. Gaeuman, Oberlin; Darrel D. Gant, Caldwell; Jack M. George, Columbus; Kenneth L. Gerson, Cleveland Heights; John B. Gibbs, Athens; Ian G. Gill, Cleveland; Richard M. Goodman, Chillicothe; Harold E. Grover, Oak Harbor; Alan Josef Gutman, Cleveland;

Gordon E. Hanusek, Hamilton; Richard E. Hartle, Kenton; Walter H. Hauser, Columbus; Thelma E. L. Herwig, Toledo; Theodor F. Herwig, Columbus; Donald E. Hoffman, Marion; Robert L. Holladay, Hillsboro; Asher O. Hoodin, North Bend; Stewart B. Hoover, Welshfield; Thomas K. Huggins, Bucyrus; H. Robert Hume, London;

William H. James, Warren; Edward A. Johnson, Gahanna; Kenn H. Johnson, Hiram; Eugene S. Jurczyk, Lorain;

Merlin W. Kampfer, Maumee; Richard A. Katz, Canton; Daniel P. Kenny, Brewster; Jack D. Kerth, Dayton; Paul T. Kinkade, Zanesville; Marion E. Kintner, Alvordton; Alan H. Klein, Springfield; Richard M. Klein, New Philadelphia; Donald R. Kmetz, Rocky River; Ernest Kopstein, Cleveland Heights; Edward A. Kuehn, Toledo; Herbert P. Lash, Cleveland;

Kenneth L. Learey, Columbus; Victor G. Lenzo, Newcomerstown; William L. Licklider, Columbus; John R. Linscott, The Plains;

Jay S. Malkoff, Youngstown; George J. Mallo, Akron; Thomas R. Marshall, Cleveland; Kayoshi Masuoka, Akron; Clarence L. Maxwell, Hilliards; Robert H. McCoy, Circleville; John F. McHugh, Shelby; Duane D. Mehlman, Port Clinton; Ernest S. Melaragno, Columbus; Henry C. Mellette, Johnstown; Morton D. Merchey, Youngstown; Donald E. Mills, Mansfield; Paul W. Montgomery, Columbus;

Donald H. Naftulin, Fremont; Darell E. Nicodemus, Columbus; Edward J. Noble, Jr., Grove City; John D. Nofzinger, Toledo; Joseph F. Oser, Jr., Barberton; Michael O. Phillips, Marion; Thomas A. Picard, Conneaut; Herbert L. Queen, Struthers;

Walter W. Randolph, Jr., Toledo; Lloyd F. Redick, Jenera; William B. Reinbold, Cuyahoga

Have You Voted in the OSMA Poll on Whether or Not Physicians Should Be Included Under Federal Social Security?

Each member of the Ohio State Medical Association has been mailed a folder and ballot on the subject "Should Physicians Be Included in the Federal Social Security Program?" The ballot is to be marked "yes" or "no" and returned to the Columbus Headquarters office, 79 E. State Street where the returns will be tabulated by a special committee.

The poll is being made on order of The House of Delegates at its last meeting in Cincinnati. The results are to be transmitted by OSMA delegates to the House of Delegates of the American Medical Association at the December meeting.

Deadline for returning the ballot is October 31.

Members who wish to refresh their memories on arguments for and against Social Security for physicians are invited to read the series of articles that have appeared in *The Journal* at the direction of the House of Delegates. These arguments appeared in the following issues on pages indicated: July issue, pages 868-884; August issue, pages 1010-1020; September issue, pages 1138-1150.

Falls; Roger L. Rian, Mt. Vernon; Eugene M. Ross, Cleveland;

Bruce J. Sand, Columbus; James B. Sauers, Greenwich; Victor M. Schultz, Canton; Allan J. Schutt, Defiance; Ann Holtzmuller Schutt, Defiance; Donald W. Shanabrook, Akron; Richard P. Sharp, Dayton; William V. Sharp, Cuyahoga Falls; Harry J. Shaver, Columbus; Edward L. Sherrer, Jr., Rocky River; John P. Shultz, Urbana;

Frank S. Sikora, Lorain; Henry R. Silverman, Jr., Dayton; Frank Fuller Snyder, Salem; Robert P. Stanton, Hamden; William A. Stewart, Bowling Green; Alfred E. Stockum, Canton; Frank W. Stroebel, Cleveland; Richard B. Stuart, Pataskala; Karoly Szentendrey, Cleveland;

Richard F. Taylor, Columbus; John W. Terlesky, Cleveland; Donald M. Thaler, Painesville; Russell L. Thomas, Cuyahoga Falls; Richard P. Thorn, Akron; John Vasko, Cleveland; Edward H. Vogel, Bellevue;

Leo T. Wagenbrenner, Columbus; Don W. Wehling, Barberton; Lawrence S. Weisman, Columbus; Donald E. Weiss, Cleveland; Larry L. Weiss, Akron; Richard L. Whitmer, Vandalia; Thomas E. Wilson, Columbus; Murray G. Winchell, Fairport Harbor; James McG. Wright, Columbus; Thomas E. Wright, Worthington;

Barry Yulish, Cleveland; Mark H. Zangmeister, Lithopolis; Charles E. Zepp, Columbus.

University of Cincinnati—William R. Adkins, Huntington, W. Va.; William M. Adler, Cincinnati; Taki Anagnoston, Dayton; Robert B. Arnold, Lebanon; Arthur K. Asbury, Cincinnati;

George Benzing, III, Hamilton; Carter R. Bishop, Cincinnati; Daniel T. Bolovan, Warren; Gerald E. Boyd, Lima; Thomas E. Broderick, Cincinnati; Cecil R. Burkhart, Fairborn; Patrick A. Clement, Euclid; John C. Damron, Mansfield;

George T. Donovan, Fort Wright, Ky.; William D. Dooley, Middletown; Albert Dreskin, Irvington, N. J.; William V. Dugan, Barberton; Harold H. Earnhart, Waynesville; Thomas E. Egan, Ft. Mitchell, Ky.;

Sheldon Farber, Cincinnati; Robert G. Feldman, Cincinnati; Edward E. Fisher, Cleveland; Richard K. Goodrich, Zanesville; Gary J. Greenlee, Manchester; John D. Gundzik, Cleveland;

Fouad A. Halaby, Cincinnati; Daniel Hartston, New York City; Joyce N. Herrold, Lancaster; William B. Hofmann, Trotwood; Donald J. Holzberg, Cincinnati; Marion R. Huston, Millersburg; Donald B. Jaffe, Cincinnati; George P. Janetos, Hamilton; Richard J. Jarvis, Canton; Jerry W. Jones, Covington, Ky.;

George J. Kabat, Jr., Cincinnati; Richard I. Kent, Cincinnati; Elmore A. Kindel, Jr., Cincinnati; Philip D. Kinnard, Bellefontaine; Edward J. Kremchek, Cleveland;

Jack L. Maffett, Carrollton; Donald J. McSurdy, Harrisburg, Pa.; William S. Michael, Jackson; Rudy G. Moc, Vermilion; Yvonne M. Mohlman, Mariemont; Myron Moshowitz, Cincinnati;

Charles H. Neilson, Sunbury; Edward D. Nusbaum, Richmond, Ind.; Thomas C. Payne, Dayton; Homer D. Petrou, Shelbyville, Ky.; Robert J. B. Price, Tipp City; Casimer F. Radkowski, Cleveland; Robert E. Rakel, Cincinnati; Herschel M. Richter, Cincinnati; Robert E. Robbins, Lexington, Ky.; Gerald A. Rosenberger, Defiance;

Martin Saidleman, Lebanon; Donald J. Schwieterman, New Bremen; William E. Scully, Cincinnati; Otto F. Sieber, Jr., Cincinnati; Donald P.

Smith, Sycamore; Duane H. Smith, Lyons; Calvin R. Stewart, Hubbard; James I. Tennenbaum, Cincinnati;

Thomas U. Todd, Cincinnati; Ramon D. Turman, Lorain; Harold D. Udelman, Cincinnati; Rudolph W. Vollman, Southgate, Ky.; William B. Walters, Archbold; Roger F. West, Cincinnati; John Allen Whitesel, III, Oxford; Samuel M. Wigser, Cincinnati; Robert A. Wolf, Cincinnati; Karl E. Yaple, Cincinnati.

Western Reserve University—Donald Anthony, Jr., Conneaut; Franklin J. Arnold, Jr., Hartville; Lester Baker, Jr., Decatur, Ill.; John H. Bauman, Bluffton; Richard L. Baumgartner, E. Cleveland; Abraham B. Bergman, Cleveland Heights;

James Borden, Cleveland; William D. Bradford, Rochester, N. Y.; William R. Brinker, Westlake; Kenneth A. Brown, Warren; John M. Bucher, Jefferson, Pa.; Charles W. Burmeister, Johnstown, Pa.; Herman Buschke, Cleveland; Edward S. Bush, Cleveland; William T. Butler, Webster Groves, Mo.; Janet P. Butte, Steubenville;

Patricia Caughey, Detroit, Mich.; Donald E. Christensen, Cleveland; E. Christine Costley, Liberal, Mo.; Charles F. Crone, Massillon; Ted E. Cull, Ft. Recovery; Robert L. Dillenkoffer, New Orleans, La.; Edward D. Eckman, Jr., Jamestown, N. Y.; William M. Emery, Ashland;

Norbert Felber, University Hts.; Ronald B. Fleming, Berea; Richard B. Fratianne, Cleveland; Parrish W. Garver, Cleveland; Perry Anderson Henderson, Cleveland; David A. Hunt, Dayton; David E. Jenkins, Jr., Niles; John A. Jennings, Xenia; Edward W. Jensen, Cleveland;

Sheldon Kaffen, Cleveland Heights; Charles M. Klein, Rocky River; Mathilde S. Kline, Canton; Addie L. Klotz, Lakewood; Theodor Kolobow, Columbus; John M. Kuldau, Sandusky;

Irwin H. Lepow, Cleveland Hts.; Phillip I. Lerner, Cleveland; Wm. P. Mahoney, Jr., Cleveland; Richard B. Markey, Shaker Heights; Edward L. Mitchell, Cleveland; Richard E. Myers, Shaker Heights; John L. Nieman; Cleveland Heights;

Sonya S. Oppenheimer, Cleveland; James L. Phillips, West Middlesex, Pa.; Richard L. Porus, Cleveland; Stephen A. Pye, Jr., Cuyahoga Falls; Martin S. Roginsky, Cleveland; Arthur L. Rosenbaum, Lorain; Eugene Ross, Cleveland Hts.;

Howard B. Sauder, Wheeling, W. Va.; Mario P. Scibetta, Cleveland; Sadja Silberger, New Milford, Conn.; Richard E. Simmons, Akron; Raymond B. Strauss, Cleveland; Robert H. Stults, Miami, Fla.; Howard S. Sudak, Cleveland; Richard A. Thompson, Cleveland; Philip Thorngate, Monterey, Calif.; Frank C. Tiberio, Youngstown;

Donald E. Walker, Canonsburg, Pa.; Daniel T. Weidenthal, Shaker Heights; Herbert D. Weintraub, Cleveland Hts.; Sanford R. Weiss, South Euclid; August H. Wells, Elma, N. Y.; William B. Wentz, Cleveland; Charles R. Wolf, Xenia.

Graduates of Medical Schools of Other States and Canada (alphabetical by medical school of graduation)—Alfred W. Jackson, Jr., Hartville, Cornell Univ.; Donald F. Armento, Euclid, Georgetown Univ.; Thomas J. Fauble, Swanton, Georgetown Univ.; Walter E. Badenhausen, Jr., New York City, Hahnemann Univ.; William E. Masters, Warren, Hahnemann Univ.;

Jerome A. Wensinger, Marion, Loyola Univ.; Thomas R. Mainzer, Huntingdon, Pa., Jefferson Med. Col.; Lowell D. Mann, Clayton, Jefferson Med. Col.; Robert L. Michael, Jackson, Jefferson Med. Col.; Grafton F. Sieber, Cleveland, Jefferson Med. Col.; Lucius F. Sinks, Columbus, Jefferson Med. Col.; E. Milton Witthoff, Jr., Chicago, Ill., Jefferson Med. Col.;

Edward Morris, Mentor, Northwestern Univ.; Fred H. Tilock, Lorain, Temple Univ.; Joyce E. Howell, Cincinnati, Woman's Med. Col.; Marilyn F. Mahaffey, Fredericktown, Woman's Med. Col.;

Charles M. Alexander, Toledo, Univ. of Chicago; Paul M. Plueddeman, Cincinnati, Univ. of Illinois; William M. Sermonte, Cincinnati, Univ. of Illinois; Walter Bjarnesen, Levonia, Mich., Univ. of Michigan; Richard A. Morin, Alpena, Mich., Univ. of Michigan; William H. Richmond, Toledo, Univ. of Michigan; James H. Stage, Ironwood, Mich., Univ. of Michigan;

Richard W. Emmons, Rockville, Md., Univ. of Pennsylvania; John A. Murray, Carrollton, Univ. of Pittsburgh; Rodney J. Valentine, Los Angeles, Calif., Univ. of S. California;

Warren E. Underhill, Newark, McGill Univ., Montreal; Donald G. Lehocz, Kitchener, Ont., Univ. of Ottawa, Ontario; John M. Day, Toronto, Canada, Univ. of Toronto; Donald L. Bebensee, Bathwell, Ontario, Univ. of W. Ontario; John G. Margrett, Ontario, Canada, Univ. of W. Ontario; Ralph C. Smith, Cleveland, Univ. of West. Ontario, Canada.

Graduates of Foreign Medical Schools (alphabetical by country in which school of graduation is located)—Irving Marcus, Richmond, Va., Univ. Adelaide, Australia; Alois W. Toegel, Hammonton, N. J., Univ. of Graz, Austria; Joseph C. Ungvari, Kirkwood, Mo., Univ. of Graz, Austria; Jacob Finkelstein, Brooklyn, N. Y., Catholic Univ. of Louvain, Belgium; Felix C. Lewkowicz, New York City, Univ. of Paris, France;

Carrie Siedentop, Park Forrest, Ill., Univ. of Berlin, Germany; Vytautas P. Digrys, Hammonton, N. J., Univ. of Erlangen, Germany; Haralds E. Birznieks, Dayton, Univ. of Frankfurt-Main,

(Continued on Page 1340)



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John P. King, Dayton, Nat'l Univ. of Ireland; Hugh C. O'Connor, Toledo, Royal College of P. & S. of Ireland; Lino M. Lapenna, Columbus, Univ. of Bari, Italy; Joseph J. Bartolomeo, Syracuse, N. Y., Univ. of Bologna, Italy;

Kenneth J. Munden, Chicago, Ill., Univ. of Madrid, Spain; Basilio Gonzales, Cambridge, Univ. of Valencia, Spain; George C. Lakatos, New York City, Univ. of Berne, Switzerland; Harry Chovnick, Columbus, Univ. of Geneva, Switzerland; Charles P. Felton, New Orleans, La., Univ. of Geneva, Switzerland; Norman Pearl, New York City, Univ. of Geneva, Switzerland;

Elias A. Husni, Cleveland, American Univ. of Beirut, Lebanon; Zouhair Yassine, Cleveland, French Univ. of Beirut, Lebanon;

Ali Riza Dedehayir, Mansfield, Univ. of Istanbul, Turkey;

Carlos R. Diaz, Chicago, Nat'l Aut. Univ. of Mexico; German Oritz, Wheeling, West Va., Nat'l Aut. Univ. of Mexico; Elmer E. Raus, Fairfield, Nat'l Aut. Univ. of Mexico;

Eliseo M. Colli, Carroll, Ill., Univ. of Havana, Cuba;

Alfredo A. Ayala, W. Warwick, R. I., Nat'l. Univo of San Marcos, Peru.

Ohioans Covered By Hospital-Doctor Insurance Total 8,447,000

The number of people in Ohio covered by voluntary health insurance has reached a new high, the Health Insurance Council reports. The Council estimates that over 8,447,000 persons in the state now are protected by some form of insurance designed to help pay hospital and doctor bills.

The number of people covered by some form of health insurance in the nation, according to a Council estimate, is now 123,000,000, or 72 per cent of the total U. S. civilian population.

The Council survey, based on reports of insurance programs of insurance companies, Blue Cross-Blue Shield and other health care plans, points out that the 8,447,000 persons covered by hospital expense insurance in Ohio as of December 31, 1957, surpasses the 1956 year-end total of 8,181,000.

The number of people with surgical expense insurance, which helps to defray the cost of physicians' charges for operations, climbed to 6,941,000 as compared to 6,498,000 in 1956.

Persons protected by regular medical expense insurance, providing for doctor visits for non-surgical care, rose to 4,318,000, compared to 3,587,000 the year before.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since August 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County (Cleveland unless otherwise indicated)
Albert E. Baldwin, Jr.
John R. Boswell
Charles M. Branden
Ying Chei Chen
Ivan Dimitroff
Roy J. Fischer
James H. Fry
Kingsbury G. Heiple
Robert M. Hess
L. Morris Jones
William E. Kincaid
Victor Koby
Ralph J. Kovach
Robert J. Lancaster
Amore Longano
Robert V. McMahon
Nancy B. Michael
Armand Moettus
Marie Pancner
Remberto Rangel
Lee I. Rubinstein
Vladimir Shkilnyk
Kathryn H. Svec
Thomas G. Geoghegan, Bedford

Franklin County
Henry P. Sengelmann, Columbus

Greene County
Harold J. Laughlin, Fairborn

Hamilton County
Edmund Strauss, Cincinnati

Harrison County
Samuel A. Chaney, New Athens

Huron County
William B. Elderbrock, Wakeman
William R. Graham, Wakeman

Lorain County
Howard H. Smead, Lorain

Mahoning County
Bernard Taylor, Youngstown

Miami County
Robert A. Rehm, Piqua
Dominic A. Thomas, Piqua

Summit County
George A. Miller, Jr., Akron

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W. C. U. Bldg. Quincy, Illinois

Central Ohio Heart Association Offers Fellowship Grants

Graduate students, physicians and investigators interested in heart research are invited to apply for fellowships now available from the Central Ohio Heart Association, 50 E. Broad St., Columbus.

Research grants are made to non-profit institutions in direct support of a particular investigator. Prospective investigators must apply for a specific program of research under their direction. Grants are awarded in support of research in the cardiovascular field or basic sciences related to it for periods of a year or more.

The Association is also taking applications for fellowships for research and training at Central Ohio institutions. Fellowships are available for one year and carry an annual stipend of from $4,800 to $7,000 a year.

A second type of fellowship, a clinical fellowship, is open to those with an M. D. and two years' residency. The clinical Donald Mahanna Fellowship is also open with the work being conducted at the Heart Station, University Hospital, Columbus. The stipend is $7,000 a year. Deadline for grant-in-aid applications is November 1, 1958, for fellowships starting July 1, 1959.

Physicians of Central Ohio Invited to Columbus Academy "Clinic Day"

Final plans for the second annual "Clinic Day" meeting of the Columbus Academy of Medicine have been announced.

This all day meeting on Saturday, November 1, will be held in the Veterans Memorial Building, 300 West Broad Street in Columbus.

Registration will be held from 8:30 until 9:30 A. M. with pre-registration necessary by Wednesday, October 29, by contacting Dr. Robert A. Heilman, Columbus Academy of Medicine, 79 E. State Street, Columbus 15, Ohio. The Registration cost will be $5.00 or $7.50 if luncheon is desired. Individual luncheons in the Post Meeting Rooms will be held with the guest speakers and will feature a question and answer period.

Physicians may be reached at CA 4-6116 for emergency telephone calls. Adequate parking facilities are located adjacent to the building.

The completed program has been announced as follows:

8:30—Registration

9:30—**Radiation Hazard in Medicine** — Paul

(Continued on Next Page)



(Columbus Clinic Day—Continued)

Hodges, M. D., Professor of Radiology, University of Chicago, Chicago, Illinois

10:00—**Fat, Diet and Atherosclerosis**—Ray W. Gifford, M. D., Consultant, Section on Medicine, Mayo Clinic, Rochester, Minnesota

10:30—Coffee

11:00—**Newer Agents in Diabetes**—Rachmiel Levine, M. D., Chairman, Department of Medicine, Director of Metabolic and Endocrine Research, Michael Reese Hospital, Chicago, Illinois

11:30—**Prevention of Cancer, Forty Possible Means**—Robert J. Samp, M. D., Department of Surgery, Tumor Clinic, Wisconsin University School of Medicine, Madison, Wisconsin

12:00—Luncheon—Post Meeting Rooms, 2nd floor)

1:30—**Present Studies in Tissue and Organ Homotransplantation**—Joseph E. Murray, M. D., Director of Surgical Research Laboratories and Associate in Surgery, Harvard Medical School, Boston, Massachusetts

2:00—**Care of the Advanced Cancer Patient**—Panel Discussion

Moderator:

Charles A. Doan, M. D., Dean, College of Medicine, Ohio State University

Collaborators:

George T. Pack, M. D., Attending Surgeon, Memorial Hospital, New York City

Chester Southam, M. D., Associate, Sloan-Kettering, New York City

Bronson S. Ray, M. D., Professor of Neurosurgery, Cornell University, New York City

James W. Carpender, M. D., Professor of Radiology, University of Chicago, Chicago, Illinois

4:00—Adjournment

The American Academy of General Practice has stated this program is acceptable for 4½ hours Category I Credit for its members. Interested physicians of other counties are cordially invited to attend.

Ralph Creer, director of motion pictures and medical television for AMA is to go to Tokyo next April as a guest of the Japan Medical Congress. Mr. Creer will organize and direct an International Medical Film Exhibition as part of the congress' 15th general assembly. He also will deliver several illustrated lectures to the faculty of the two medical schools in Japan.



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More Federal Aid To States For Civil Defense

Recent legislation which amends the Federal Civil Defense Act of 1950 provides for greater Federal leadership and financial assistance to the States in the development of civil defense plans and preparations. The following changes in existing procedures reflect the new concept of Federal responsibility:

The declaration of policy in the Federal Civil Defense Act is changed to make the responsibility for civil defense a joint one between the Federal Government and the several states and their political subdivisions. Heretofore, the Federal Government provided coordination and guidance while the responsibility was primarily that of the states and their subdivisions.

The Federal Government is authorized to purchase radiological instruments and detection devices such as Geiger counters and to grant them to the states. This authority is limited to a five-year period and not more than $35 million may be appropriated for this purpose in any one year.

The prohibition against Federal financial contributions to states for civil defense personnel and administrative expenses or for personal equipment for state and local civil defense workers is abolished. To be eligible for grants under this program, states must have approved civil defense programs consistent with the national plan, the plan must be state-wide and administered by a single state agency, employees must be under the merit system and there must be a full-time civil defense director or deputy director.

The former restriction against contributions to the states for the cost of personal equipment for state and local civil defense workers is eliminated in order to permit the Federal Government to bear a part of the cost of providing uniforms to persons performing police, fire and rescue work that they might be readily identifiable by the general public in an emergency.

Federal assistance would be subject to a 50 per cent contribution by the states and local governments toward administrative and personal expenses and the cost of items of personal equipment. The authority is limited to five years.

Appropriations for personnel and administrative expense contributions may not exceed $25 million per year and appropriations for contributions for items of personal equipment may not exceed $2 million per year.

A limitation of $100,000 on amounts appropriated annually for travel expenses and per diem allowances of persons attending civil defense schools is increased to $300,000. However, the states are required to bear one-half of these expenses whereas formerly the total cost was borne by the Federal Government within the $100,000 limitation. This authority is also limited to five years.

Two County Societies Hold Sports Injury Meets

The Lorain County Medical Society and the Portage County Medical Society have joined the list of local medical societies in Ohio which have conducted high school athletic injury conferences.

In August, both sponsored pre-season conferences for high school coaches throughout their respective counties, and both reported an enthusiastic reception.

The Lorain program is typical of the format used by the county societies in these conferences, and drew 78 persons representing school administration, athletic departments, Parent - Teacher Associations, referees and interested physicians.

Dr. Franklin H. Schaefer, Elyria, was moderator. Dr. Ben V. Myers, Lorain County Medical Society president, and C. A. Gibbons, county schools superintendent, introduced the purpose of the conference.

Built on areas of responsibility, the program included "Responsibility of the School Coach," by Joe Hudak, Amherst coach; "Responsibility of School Administration," by W. H. Jones, Avon schools superintendent, and "Responsibility of Physician and Dentist," by M. C. Kolczun, M. D.

In discussing specific injuries, their prevention, detection, immediate and long-time treatment, Dr. Conrad T. Rusin spoke on abdominal injuries, Dr. Joseph M. Strong, on injuries to extremities; Jack Underman, D. D. S., injuries to mouth and teeth, and Dr. Kolczun, injuries to head and face. The speakers then served as a panel for a question and answer session following the talks.

The society's planning committee for the conference included Drs. I. C. Riggin, chairman, Marion G. Fisher, W. H. Jones, Kolczun, L. C. Meredith and Dr. Schaefer.

The Portage County conference, which also included the athletic department at Kent State University, is to be an annual event if interest merits, and the Lorain County society has announced that its conference will be repeated in a similar or extended form if interest merits.

Physicians participating in the Portage County conference included Dr. E. A. Webb, chairman; Dr. T. Adamle (pre-season examination) Dr. R. Dumm (heart in athletics), Dr. R. McCormick (head and spine injuries), Dr. N. Chang (knee injuries), Dr. C. Voorhis (ankle injuries), Dr. J. Fiala (internal injuries), and Dr. C. Whitsett (x-ray and injuries).



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...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

...the prompt and prolonged activity of timed-release medication

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TRIAMINIC®	50 mg.
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pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextro-methorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-para-aminophenol)	325 mg.

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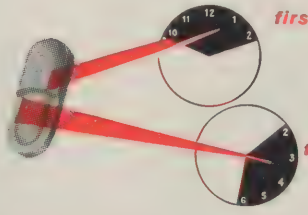
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Hospital Association To Present Institute on Infections

A one-day institute to present factual and useful information regarding the prevention and control of Staphylococcus infections in hospitals, has been announced for Wednesday, October 15, by the Ohio Hospital Association. The program will begin at 9:00 a. m. in the Hall of Mirrors, Deshler-Hilton Hotel, Columbus.

The OHA announced: "The Educational Committee and the Committee for this Institute, feel that this is a very serious problem for hospitals. Every hospital has a potential problem of infections and it appears that the number of such infections is increasing."

A registration fee of $10 per person includes the luncheon. The institute is of particular interest to hospital administrators, assistant administrators, operating room supervisors, chiefs-of-staff, directors of nursing and housekeepers. All physicians interested in the subject are invited. The program has been announced as follows:

Presiding at morning and afternoon sessions: Edgar O. Mansfield, superintendent, White Cross Hospital, Columbus.

Greetings—Roger Sherman, president, Ohio Hospital Association and administrator, Children's Hospital, Akron.

Introduction to the Problem, Dr. Peter A. Volpe, administrator, University Hospital, Columbus.

Medical Aspects of the Control of Infections, Dr. Kenneth M. Schreck, assistant professor of microbiology, School of Medicine, Temple University, Philadelphia. Discussion to follow.

Nursing Aspects of the Control of Infections, Jean Reed, R. N., operating room supervisor, University Hospital, Columbus. Discussion to follow.

Luncheon.

Administrative Aspects of the Control of Infections, Norman D. Bailey, Ph. D., executive director, Grant Hospital, Chicago.

Panel Discussion — Audience Participation, Dr. Volpe as moderator, with the foregoing speakers as members of the panel.

Summary, Mr. Mansfield.

Presentation of Certificates.

William Hetherington, executive publisher of the AMA magazine, *Today's Health,* has resigned to accept a post with *Reader's Digest.*



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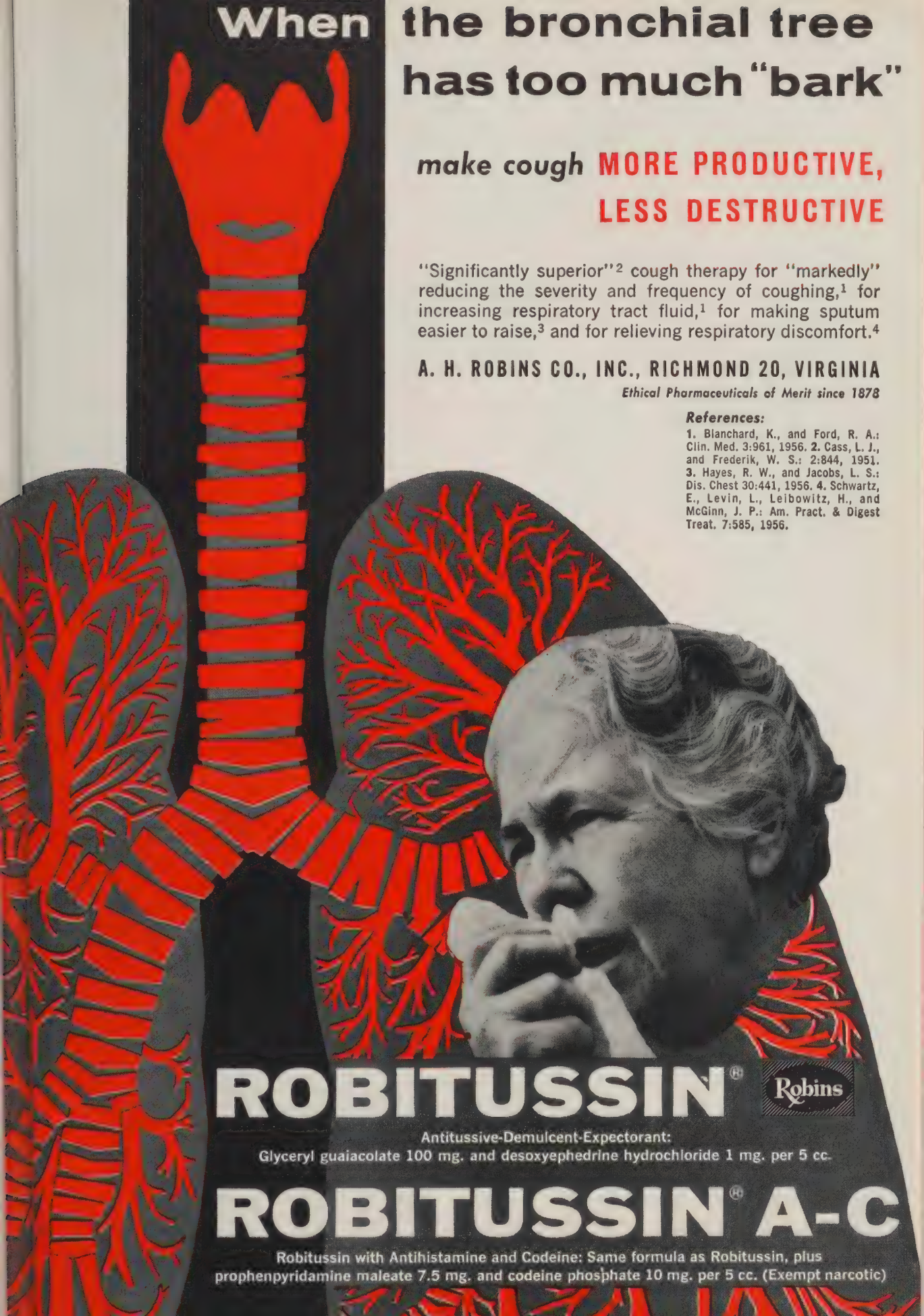
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References:

1. Blanchard, K., and Ford, R. A.: Clin. Med. 3:961, 1956. 2. Cass, L. J., and Frederik, W. S.: 2:844, 1951. 3. Hayes, R. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956. 4. Schwartz, E., Levin, L., Leibowitz, H., and McGinn, J. P.: Am. Pract. & Digest Treat. 7:585, 1956.



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In Memoriam . . .

Ralph W. Beede, M. D., Youngstown; Ohio State University College of Medicine, 1937; aged 63; died August 19; former member of the Ohio State Medical Association; member of the American Academy of General Practice. A native of Youngstown, Dr. Beede served all of his professional career there. He was a member of the Methodist Church, the PSA, a national photography association, and the American Rose Society. Surviving are his widow, a son, three brothers and two sisters.

Frank W. Case, M. D., Cincinnati; Miami Medical College, Cincinnati, 1907; aged 75; died August 25; member of the Ohio State Medical Association. Dr. Case practiced his profession in Cincinnati for nearly 50 years. He was a member of the Episcopal Church. Surviving are his widow, a daughter, and a son, Dr. Victor Case, who was associated with his father in practice.

George T. Flesher, M. D., Huntington, West Virginia; Medical College of Virginia, 1934; aged 51; died August 14; former member of the Ohio State Medical Association; diplomate of the American Board of Otolaryngology. Dr. Flesher formerly practiced in Columbus and in Willard. A daughter survives.

Francis F. Heyroth, M. D., Ph. D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 63; died August 17; member of the Ohio State Medical Association and the American Medical Association; member of the American Chemical Society; Dr. Heyroth retired in 1957 as assistant director of the Kettering Laboratory and associate professor of industrial toxicology and biological chemistry at the University of Cincinnati. A former vice-president of the Cincinnati Board of Health, his appointments included those on the National Advisory Dental Research Council of the U. S. Public Health Service and on the National Research Council panel on environmental cancer. Surviving are his widow and two daughters.

Lucy Michaelis, M. D., Cleveland; Friedrich-Wilhelms University Faculty of Medicine, Berlin, 1922; aged 61; died August 19; member of the Ohio State Medical Association and the American Medical Association. Born and educated in Germany, Dr. Michaelis had been a practicing physician in Cleveland since 1939.

Hurston H. Morris, M. D., Portsmouth; Marquette University School of Medicine, 1926; aged 62; died August 26; former member of the Ohio State Medical Association. Dr. Morris began his practice in Fullerton, Ky., and moved to Portsmouth in 1930. His widow survives.

Franklin H. Pennell, M. D., Fostoria; Ohio State University College of Medicine, 1920; aged 63; died August 18; member of the Ohio State Medical and the American Medical Association. A native of Fostoria, Dr. Pennell served all of his professional career there. He was active in numerous civic and community affairs of the area; was a member of the Rotary Club, the Red Cross, the Masonic Lodge, the Fostoria Country Club and the Methodist Church. A veteran of World War I, he was a member of the American Legion. Surviving are his widow, a daughter and a son.

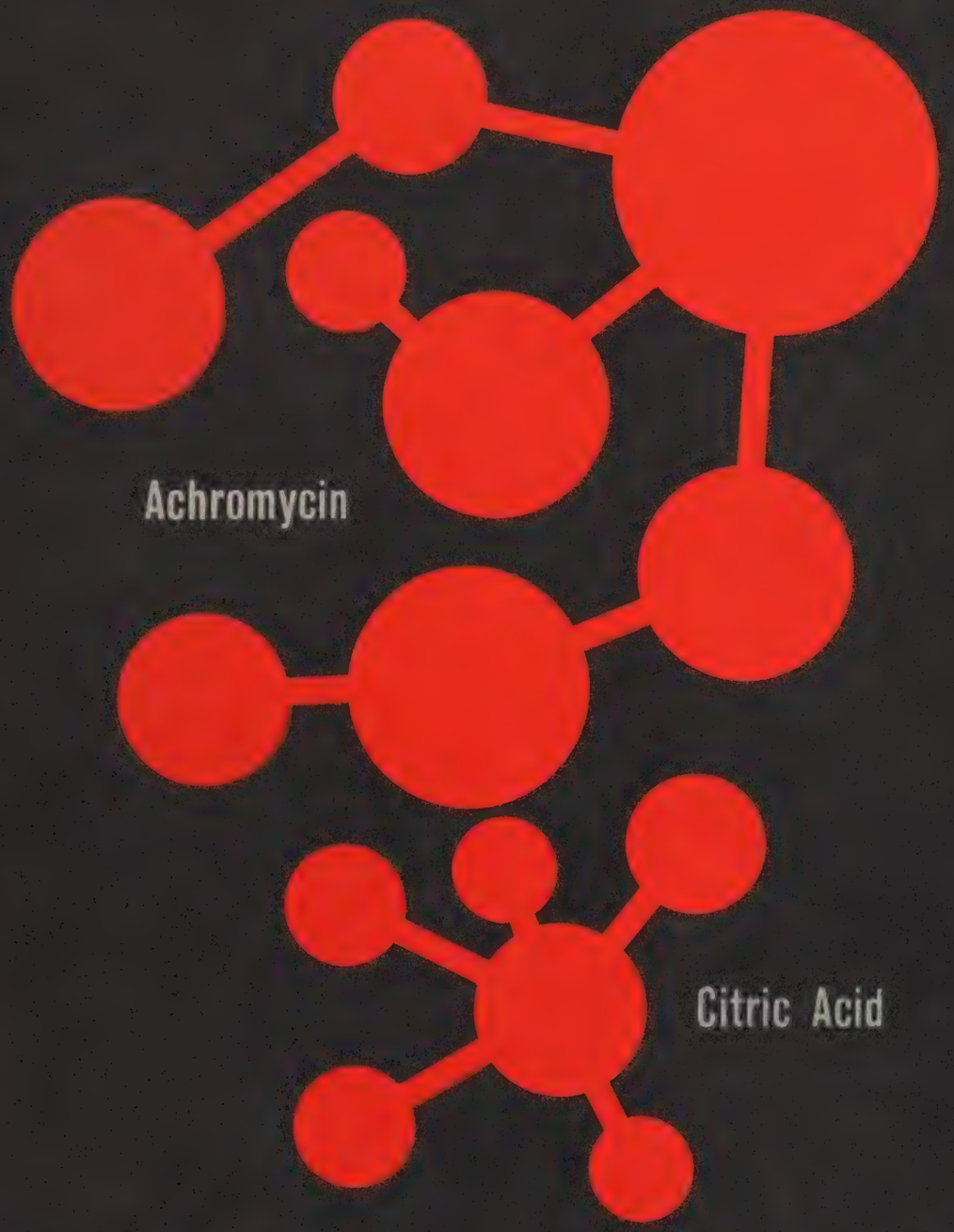
Francis S. Schwarz, Jr., M. D., Cleveland; Cornell University Medical College, 1943; aged 37; died August 31 in a traffic accident; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology; diplomate of the American Board of Ophthalmology. Dr. Schwarz began his practice in Cleveland in 1950. He is survived by his widow, his parents, a brother and two sisters.

Paul S. Williams, M. D., Santa Cruz, Calif.; Western Reserve University School of Medicine, 1931; aged 52; died August 27; former member of the Ohio State Medical Association. Dr. Williams practiced in Hubbard until about 10 years ago when he moved to Phoenix, Arizona. He moved recently to California. His widow survives.

John Francis Wright, M. D., Toledo; University of Wooster Medical Department, Cleveland, 1903; aged 78; died August 12; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award; former delegate of the Academy of Medicine of Toledo to the OSMA. Dr. Wright served all of his professional career in the Toledo area with the exception of time served in the Medical Corps during World War I. He was a member of St. Mary's Church of Toledo, and the American Legion. Survivors include his widow; a son, Dr. John J. Wright; a daughter, and two sisters.

Richard Stalvey, of the AMA Public Relations Department, has taken up his new duties as assistant executive director of the Los Angeles County Medical Society.

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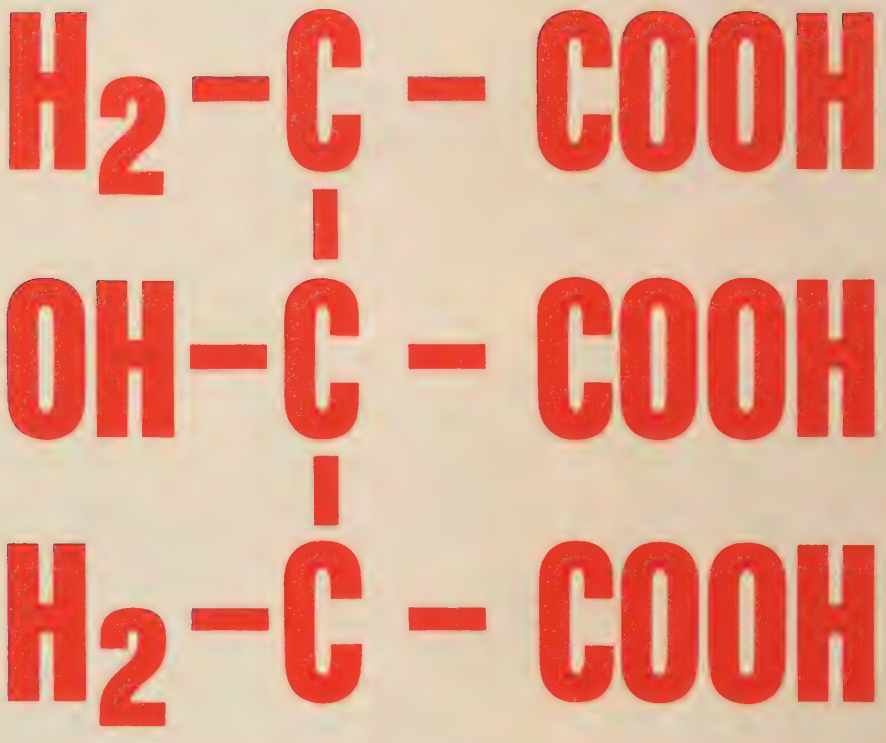
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ASSURES EVERY PATIENT PRECISE ANTIBIOTIC ACTION UNDER THE VARIED CONDITIONS OF REALISTIC CLINICAL PRACTICE

produces optimal gastric conditions

Ideally, most antibiotics are given on an empty stomach. Since citric acid helps control unfavorable variances in gastric content, conditions in the stomach are optimal with ACHROMYCIN V tetracycline with citric acid.

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Sequestering of antibiotic molecules by free metallic ions, always present in the intestinal tract, can deprive patients of a full therapeutic dose. The three active carboxyl radicals which protect the action of ACHROMYCIN V trap these free cations and allow unimpeded antibiotic absorption.

provides for peak antibiotic action

At the site of infection where, in essence, all antibiotics are proved, ACHROMYCIN V combats a wide range of pathogens under optimal tissue conditions. Citric acid, a factor of medically established value in the natural acid-base regulating mechanism of the G.I. tract, facilitates a more complete, and rapid antibiotic action.

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Some WC Fees Increased . . .

Raises Granted by Bureau Less Than Recommendations of OSMA; New Schedule Is Effective for All Services Rendered on or After October 1

A NUMBER of items in the Bureau of Workmen's Compensation Fee Schedule have been increased for services rendered by physicians in BWC cases on and after October 1, 1958.

The principal increases are in fees for first treatment at home, office and hospital and subsequent treatments at office and home.

The Bureau and the State Industrial Commission did not increase the fees to the extent requested by the Ohio State Medical Association through the Council and the Committee on Industrial Health and Workmen's Compensation.

Representatives of the Association had held a number of conferences on the subject with officials of the BWC and the State Industrial Commission. Statistical information was presented substantiating the Association's requests. This included data on the increased cost of practicing medicine, including office personnel, rent, dressings, drugs, etc.

Comparison Tabulation

The following tabulation shows fees prior to October 1, 1958; amounts recommended by the Ohio State Medical Association; and the fees set by the Bureau, effective October 1, 1958:

	Prior To October 1, 1958	Asked By OSMA	Granted By Bureau
First treatment at office (day)	$5.50	$7.00	$6.00
First treatment, home or hospital (day)	7.00	8.00	7.50
First treatment, office, home, hospital (night emergency 9 PM to 7 AM) (Also requested that "9 PM" be changed to "8 PM.")	9:00	10.00	9.00
Subsequent treatment at office, including ordinary medication and dressings	3.00	4.00	3.25
Subsequent treatment at home, including ordinary medication and dressings	4.00	5.00	4.25
Subsequent treatment at hospital	3.50	4.00	3.50
Mileage beyond corporation limits, per mile one way	.50	.60	.50
Tetanus antitoxin (prophylactic) in addition to the regular treatment fee	2.00	3.00	3.00
Gas bacillus and tetanus antitoxin combined (prophylactic)	3.00	4.00	4.00

Anesthesia Fee Increased

Acting on a request from the Ohio Society of Anesthesiologists for more adequate compensation for the administration of anesthesia during prolonged operations, the fee schedule for anesthesia was revised by eliminating the item "Second thirty minutes or fraction thereof, $10.00" and substituting the item "Each additional thirty minutes or fraction thereof, $10.00."

Statement by Administrator

Commenting on his decision and that of the State Industrial Commission, James L. Young, BWC Administrator said:

"We feel that the increases as granted are commensurate with the present economic situation and the proper administration of the Workmen's Compensation Act."

Mr. Young estimated that the increases granted would add approximately $750,000 annually to the amount paid to Ohio physicians for the treatment of industrial accident cases. Payments to physicians in 1957 amounted to $7,827,104.24.

Fee Schedule Additions

The following items, not previously listed, were added to the BWC Fee Schedule, at the request of Dr. Addison L. KeFauver, Chief Deputy Administrator of BWC. The fees had been approved as recommended by the OSMA Committee on Industrial Health and Workmen's Compensation.

Genitourinary Procedures

*Catheter, insertion and replacement of, on home visit (in addition to regular treatment fee and including cost of catheter) $10.00

Laboratory Procedures

*Fungus, culture for (in addition to regular treatment fee) $ 5.00

(Continued on Page 1352)

HE NEEDN'T BE HIGH-STRUNG

WEIGHT REDUCTION: Obese patients may resist dieting because they fear losing the emotional security often involved in overeating. **AMBAR** helps them hold the diet line by giving them a more alert, brighter outlook. **WITHOUT JITTERS:** Methamphetamine, a potent CNS augmenter, produces less cardiovascular effect than amphetamine. In **AMBAR** it is combined with just enough phenobarbital to prevent overstimulation. **AMBAR EXTENTABS** provide 10-12 hours of appetite suppression in one controlled-release, extended-action tablet: methamphetamine hydrochloride, 10.0 mg.; phenobarbital (1 gr.) 64.8 mg. **AMBAR TABLETS** for conventional dosage or intermittent therapy contain methamphetamine hydrochloride, 3.33 mg.; phenobarbital (⅓ gr.) 21.6 mg. A. H. ROBINS COMPANY, INC., Richmond, Virginia, Ethical Pharmaceuticals of Merit Since 1878

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for patients who require higher methamphetamine dosage



Neurosurgical Procedures

Lobotomy, transorbital $100.00
Lobotomy, prefrontal $200.00

Ophthalmological Procedures

Glaucoma, operation for $175.00
Extraocular muscles, primary operation on:
One muscle $100.00
More than one muscle $150.00

Surgical (Orthopedic)

Arthrogram, injection of contrast for (exclusive of roentgenographic study) .....$ 25.00

Surgical Procedures

Saphenous vein ligation and complete stripping:
Unilateral $150.00
Bilateral $200.00
Pneumonectomy $300.00
Lobectomy $300.00
Splenectomy $200.00

Miscellaneous

*Proctoscopy and/or sigmoidoscopy (in addition to the regular treatment fee) ..$ 10.00

Corrections Made

In two items in the old Fee Schedule the asterisk, indicating that the fee allowed is in addition to the regular treatment fee had been inadvertently omitted. As corrected in the new fee schedule these items are as follows:

*Superficial x-ray therapy $5.00
*Corneal scar, treatment of, by beta-radium ..$5.00

Copies To Be Sent To Members

The Bureau of Workmen's Compensation is having a new booklet printed containing the revised Fee Schedule, rules and regulations governing the filing of claims and general information for physicians, dentists and hospitals on administrative procedures. When available, a copy of this booklet will be mailed to each member of the OSMA with an issue of *The OSMAgram.*

"Story Behind the Word" Book Published by Dr. Wain

Readers of *The Journal* will be interested in knowing that a book, *The Story Behind the Word,* has been produced by Dr. Harry Wain, Mansfield. It has been published by Charles C. Thomas, Springfield, Ill. The cost at bookstores is $8.50. The book is an alphabetical compilation of 5,700 derivations of medical terms, many of which appeared in *The Ohio State Medical Journal* during the past ten years when Dr. Wain authored *The Story Behind the Word* column of *The Journal.*

Columbus Heart Program Will Stress The Role of the Radiologist

"The Radiologist's Role in Cardiology" will be the subject of Dr. Stanley M. Wyman, chief radiologist of the Massachusetts General Hospital, when he speaks to the Scientific Council of the Central Ohio Heart Association, November 5, at 3 p. m.

All Central Ohio physicians are invited to attend the all-day session, Room-100, Starling-Loving Hospital, Ohio State University.

The program will begin at 10 a. m. with an exhibit by the OSU Department of Radiology. There is also a business meeting of the Scientific Council at 10 a. m. This will be followed at 11 a. m. by Case Rounds. Physicians are invited to send a brief summary of an interesting cardiac problem to Dr. Sidney Nelson at Heart Association, 50 E. Broad St., Columbus. The summary must be in by October 15, and include P-A and lateral films of the chest, thick Barium swallow with films: (1) frontal (2) lateral and (3) right and left posterior oblique.

The Case Rounds, which will continue after luncheon, will be a panel moderated by Dr. Wiley Forman with Dr. Wyman, Dr. Sidney Nelson, chief of radiology at OSU; Dr. William Molnar, associate professor of radiology at OSU; Dr. William Howard, chief of radiology at Children's Hospital, and Dr. Paul Jones, president of the Ohio State Radiological Society as panel members.

Farmers Moving Ahead on the Amount Spent for Health Protection

The American farmer is rapidly catching up to the city dweller in the amount of money he spends to protect his health, according to the Health Insurance Institute, citing a survey conducted jointly by the U. S. Department of Agriculture and the U. S. Bureau of the Census.

The government study showed that in 1941 farm families spent an average of $15 a person for medical care, less than half the $32 spent for members of urban families. But in 1955, the individual spending level for farmers was $63, or nearly 80 per cent of the estimated $81 laid out by city folk.

The report shows that the average farm family spent $60 for medical care in 1941. In 1955, the sum was $235, which is the equivalent of $126 in 1941 when the change in price level is taken into account.

In 1955, the report stated, some 51 per cent of farm families had some form of health insurance.

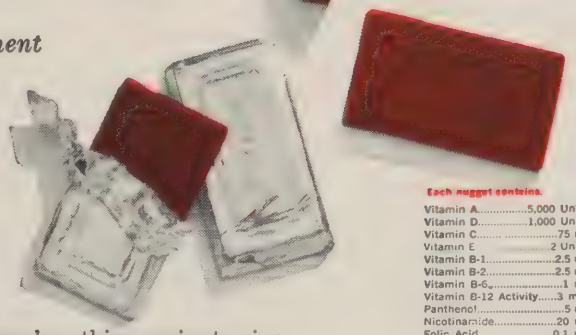
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Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

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Activities of County Societies . . .

CLERMONT

On September 17 the Clermont County Medical Society met at the DX Ranch with Dr. Carl Minning as host. The speaker was Dr. Homer Kohler, Cincinnati, who spoke on "Urinary Stones."

DARKE

The annual fall meeting of the Darke County Medical Society was held at the Greenville Country Club on September 16. A social hour was followed by dinner. After-dinner speaker was Harold Pickett, humorist.

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati was held on September 23 at the Roof Garden of the Sheraton-Gibson Hotel, where a complimentary smorgasbord was served by the Chas. Pfizer and Company, preceded by a social hour.

Dr. Jerome J. Van Gasse spoke on the subject "The Physician's Role in Living Science."

New president of the Academy is Dr. J. Robert Hudson, who assumed office to succeed Dr. George X. Schwemlein. President - Elect, who will take office as president in September, 1959 is Dr. Clyde S. Roof.

LORAIN

During the month of June the Lorain County Medical Society sponsored a special "Polio Prevention Campaign."

Using the material offered by Eli Lilly and Company, and through the cooperation of businesses, industry, civic centers and its own membership, the Society distributed throughout the county: 50 sandwich board type posters; 150 easel type posters; 15,000 leaflets or envelope stuffers; newspaper mats and 100 window or door stickers.

The County and Elyria and Lorain City Health Departments were most helpful in this effort and to remind the citizens of Lorain County of their responsibility in securing the necessary polio shots.

Lorain County was glad to report that as of late August there were no new polio cases this year.

The September 9 meeting of the Lorain County Medical Society was held at the Oberlin Inn. The Ladies Auxiliary was invited as a kick-off for their membership drive; 125 physicians and wives were present. Dr. William B. Wladecki and Dr. Ward Young, both of Elyria, were elected to active membership.

Formal reports were given by the chairmen of standing and special committees, and these revealed significant gains had been made in furthering public relations. Especially effective was the School Health Committee, (chairman Dr. I. C. Riggin) which organized and presented a well attended joint conference for prevention of injuries in the High School athlete. Significant rapport between the County Society and the County Commissioners was established through the action of a special Liaison Committee on Welfare.

A Clambake for all physicians and wives was announced for late September.

Dr. George G. Thomas, head of the Anesthesia Department of St. Francis Hospital, Pittsburgh, Pa. has been scheduled to present a program on explosive hazards in the hospital at the October 14 meeting.—Lawrence C. Meredith, M.D., Secretary-Treasurer.

PORTAGE

The regular August meeting of the Portage County Medical Society was held on the 20th at Green Trees Inn, Twin Lakes. After luncheon Mr. Frank Caulkins of the Professional Management of Cleveland, spoke on "Medical Economics of the Future."

The Portage County Medical Society sponsored an Athletic Injury Conference in the Health and Education Building of Kent State University, Kent, on August 19. The following persons participated, speaking on the subjects indicated: Dr. E. A. Webb, chairman; Dr. T. Adamle, "Pre-Season Examination"; Dr. R. Dumm, "The Heart in Athletics"; Dr. R. McCormick, "Head and Spine Injuries"; Dr. N. Chang, "Knee Injuries"; Dr. C. Voorhis, "Ankle Injuries"; Dr. J. Fiala, "Internal Injuries"; Dr. C. Whitsett, "X-Ray and Injuries." Mr. Begala, Kent State trainer, gave the trainer's slant on the subject.

Additional report on this conference will be found on page 1344 of this issue.

SCIOTO

At the regular September meeting of the Scioto County Medical Society a film, "Grand Rounds No. 7—Current Therapy of Diabetes," was shown as part of the program. Another feature was a review of 1958 Convention Highlights.

TRUMBULL

The Trumbull County Medical Society's first meeting of the new year was held at the Squaw Creek Country Club on September 17 with dinner and an evening program. The Auxiliary also shared in the event.

Dave Dennison, representative to Congress from the 11th Congressional District, was guest speaker and discussed the topic, "Recent and Pending Legislation Affecting the Practice of Medicine."

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Write for additional information regarding other uses which include management of hiccup and reflex vomiting, as well as relief of discomfort associated with laryngoscopy, esophagoscopy, gastroscopy and the passage of esophageal and gastric tubes.

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Activities of Woman's Auxiliary . . .

Ohio Auxiliaries Receive Honors At San Francisco Meeting

The thirty-fifth annual convention of the Woman's Auxiliary to the American Medical Association was held in San Francisco, California, June 23-27, at the Hotel Fairmont. Registration was 2,155 with representatives from practically every component state auxiliary including Alaska and Hawaii.

Preceding the formal opening of convention on Tuesday, 23 Ohio delegates met for the traditional Ohio Breakfast in the Garden Room of the Hotel Fairmont. Of the 47 delegates and 8 alternates elected, plus the presidential delegate, 35 registered at the convention. All alternates were raised to the status of delegate. Ohio was second in attendance when roll call was taken at the opening session.

Again Ohio has been nationally recognized as Mrs. William H. Evans, Youngstown, was elected a director for a term of two years; Mrs. Karl F. Ritter, Lima, appointed national chairman of the American Medical Education Foundation and Mrs. V. R. Frederick, Urbana, is the regional chairman of Community Service or Public Relations.

Ohio State Auxiliary won two awards:

1. Top Award in *Today's Health*—Ohio was the winner of the 1957-58 National Auxiliary Subscription Project in Group IV. In other words, Ohio won over every other Auxiliary whose membership exceeds 3001 members. The prize was $40.00. The State average for counties over 100 per cent was 8. Ohio had 25.

2. An Award of Merit for outstanding contribution to the American Medical Education Foundation. The Ohio total contribution to the AMEF was $15,069.67—a contribution of $3.00 per member. Ohio was one of 10 states receiving the Award of Merit and four of Ohio's county auxiliaries received certificates of achievement.

The Roundtables of Monday, June 23 gave the delegates an opportunity to hear the Auxiliary chairmen discuss timely and important Auxiliary topics. A tea and fashion show, Monday afternoon, honored Mrs. Paul C. Craig, president and Mrs. E. Arthur Underwood, president-elect.

The formal opening of the convention was on Tuesday, June 21. Following the introductory procedure of the convention, reports were given. Luncheon on Tuesday was in honor of the past-presidents of the Woman"s Auxiliary to the American Medical Association with Mr. Richard H. McFeely, principal of the George School, Bucks County, Pennsylvania, as guest speaker. The afternoon session featured State Projects reports as well as the reports of National Committee chairmen. The first reading of the nominating committee was given and the 1959 nominating committee was elected by ballot.

On Wednesday another general meeting was held. More reports were heard and the new by-laws were adopted by the convention. A few of the changes are as follows:

1. Instead of second to fifth vice-presidents, they are now named regional vice-presidents. Also the finance secretary, historian, and parliamentarian are now appointed officers.

2. Under committees, by-laws instead of revisions; community service instead of public relations; membership instead of organization; paramedical careers rercuitment instead of recruitment; addition of a new committee—reports; and that all committees are now standing committees.

3. Representation by the states at the National Convention in addition to the president of each constituent auxiliary or, in the absence of the president, the president-elect, one representative from each constituent auxiliary for each 300, or major fraction thereof, paid members in good standing in the National Auxiliary rather than one for each 100 or major fraction thereof.

4. The slate of the nominating committee shall be included in the call to the annual convention.

The luncheon on Wednesday honored Mrs. Paul Craig and Mrs. E. Arthur Underwood, and the guest speaker was Dr. David B. Allman, Immediate Past-President, American Medical Association. Following was the presentation of the Woman's Auxiliary contribution to the American Medical Education Foundation; the presentation of the AMEF Awards and the AMEF Certificates of Achievement. The new paramedical careers film "Helping Hands for Julie" was shown in the afternoon, after which several roundtable discussions were conducted.

Thursday concluded the convention and at this session the new National officers were elected and installed. Mrs. E. Arthur Underwood gave an inspiring inaugural address. Mrs. Underwood's theme for the year is "Safeguard Today's Health for Tomorrow."

The Woman's Auxiliary to the American Medical Association has become incorporated "not for profit" in the State of Illinois. A copy of the articles of incorporation will appear in the new

(Continued on Page 1358)

Low Dosage KYNEX* for G.U. Infections

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Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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*Reg. U.S. Pat. Off.

(Continued from Page 1356)

printed by-laws. The name is the Woman's Auxiliary to the American Medical Association, Inc. It is a federacy of its constituent auxiliaries and hereafter will be referred to as the National Auxiliary.

* * *

Fall Conference

The Woman's Auxiliary to the Ohio State Medical Association held its fourteenth annual conference on September 8 and 9.

The first day was used as a dress rehearsal for participants for the Fall Conference and the State Board Meeting.

On Tuesday the 9th, county presidents, officers, chairmen, members-at-large, and State Board members came to the Deshler-Hilton Hotel in Columbus to exchange ideas in preparation for Auxiliary work in the coming year.

Mrs. C. H. Bell, president, called the meeting to order at 9:30 a.m. She greeted members and spoke briefly of Ohio's splendid record as reported at the National Convention in San Francisco in June. Mrs. Bell then reminded members they were here to: "Decide where we are going. What we are doing, and, How we are to accomplish our plans."

She urged all to make the meeting enjoyable and educational.

Mrs. Bell introduced Mrs. C. A. Colombi, president-elect, who had charge of the Conference. Mrs. Colombi reminded members that the theme for the year is "Safeguard Today's Health for Tomorrow." She concluded her remarks with these words: "Coming together is a beginning, Keeping together is progress, Thinking together is Unity, Working together is success."

The 183 registered members representing 42 counties then adjourned to conference rooms for meetings with State officers and Committee chairmen. Instructions were given and ideas exchanged which will make for better working Auxiliaries in the year ahead.

A luncheon was held in the Grand Ballroom with Mrs. C. H. Bell presiding. Honor guests were: Dr. George A. Woodhouse, President of the Ohio State Medical Association; Mr. Charles S. Nelson, OSMA Executive Secretary; Mr. George H. Saville, OSMA Director of PR; The Reverend Paul Johnston, and State officers of the Woman's Auxiliary to the OSMA.

Mr. Nelson spoke briefly on legislative problems. He urged all to participate in a plan to get citizens registered, to study the candidates' platform, and to vote.

Dr. Woodhouse was the principal speaker. He brought greetings from the Ohio State Medical Association and congratulations for the splendid record of the Woman's Auxiliary and for the National recognition received at the Convention in San Francisco. He asked the Auxiliary to continue supporting the Ohio State Medical Association in its important projects namely: The American Medical Education Foundation, *Today's Health* and Help for the Aged.

Mrs. Charles Harding and Mrs. Ben Arnoff of Franklin County served as chairman and co-chairman of the Conference.

The next State Board meeting will be held January 15 at the Deshler-Hilton Hotel in Columbus.

A 16 per cent decrease in the average daily number of tuberculosis patients in Veterans Administration hospitals since 1954 was reported by the agency. The daily average dropped from 15,221 in fiscal year 1954 to 12,715 in fiscal year 1957, although the number of admissions and discharges remained the same. Decrease was attributed to a reduction of length of stay due to improved drug treatment.

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

March 2, 3, 4 and 5, 1959

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Sterilization and Abortion . . .

Legal and Ethical Aspects Discussed; Facts and Comments Compiled From Reliable Sources Are Assembled; Consultation With Lawyer Suggested

WHAT are the legal and ethical aspects relative to operations to produce sterility and the performance of abortions? Among the many and varied inquiries which reach the Columbus Office, this question is not uncommon.

In this article will be found facts and suggestions on these two subjects. This article should not be construed as a legal opinion—merely a review of basic facts and comments from various reliable sources. Individual physicians when they need advice on subjects such as these should confer with their own lawyer and be guided by the attorney's advice. The data here will serve as a background and should alert the physician to seek legal advice when in doubt of his status.

Ohio Law is Silent

There is no law in Ohio pertaining to sterilization, or tubal ligation.

Legal authorities are in disagreement as to whether or not a physician in Ohio may legally perform a sterilization operation, even with the written consent of the patient, when there is no definite permission granted by statute for him to do so.

Several years ago one legal authority stated "that in the absence of any law making it a crime for a physician to perform vasectomy upon an individual of sound mind with his consent, such an operation may be performed by a physician."

Other legal authorities take the opposite view, holding that in the absence of a statute making it legal for a physician to perform a sterilization operation with the consent of the individual, that a physician has no legal right to perform such an operation under any circumstances.

Some contend that the performance of a sterilization operation on an individual, with his consent, may not be illegal per se but that the performance of the operation may be a violation of general statutes pertaining to technical assault, especially the provision relating to "maim." As one authority points out, a person "may kill or injure himself by evil practice but he may not maim himself or arrange with another person to maim him."

Webster's New International Dictionary gives the following definition for maim: "Privation of the use of a limb or member of the body; a crippling; serious physical injury; hence, deprivation of something essential; a serious defect or blemish."

Section 2901.19 of the Ohio Revised Code reads as follows:

"No person shall with malicious intent to maim or disfigure, cut, bite or slit the nose, ear or lip, cut out or disable the tongue, put out or destroy an eye, cut off or disable a limb or member, of another, or throw or pour upon or throw at another scalding water, or assault another with a dangerous instrument. Whoever violates this section shall be imprisoned not less than three years nor more than thirty years. Whoever, with like intent, throws upon the person of another oil or vitriol or other corrosive acid, or caustic substance, so as to disfigure the person, may be imprisoned for life."

In the foregoing section the words "malicious intent" are used. Although the average person interprets "malicious intent" to mean a desire to injure or damage someone because of a dislike, or to repay some offense committed by the second person, these words might be interpreted by the court to mean premeditation or the fulfillment of an act planned in advance and having a specific purpose.

Public Policy

A number of authorities have argued that sterilization or depriving a person of his or her powers of procreation is an offense against public policy. One authority states, "Whatever ethical reasons may be advanced in favor of such operations in certain cases, in law they amount to illegal maiming. If this practice became general, the future of the race would be imperiled."

Other authorities have held that sterilization done with the consent of the individual and by specific contract with him, is not against public policy.

Some who have engaged in the argument also say the question must be viewed from the standpoint of medical ethics and the obligation which the physician owes his patients. One authority points out that some physicians consider sterilization justifiable as a prophylactic measure to avoid a pregnancy or series of pregnancies certain to be difficult or dangerous. This authority states that while there are good arguments in favor of sterilization in such instances, that there are other

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CONDITION	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
STUDY 1[1]					
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

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"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

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"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

methods of avoiding conception available and that even therapeutic abortions might be deemed more advisable than an operation which would end for all time the patient's ability to procreate, when the sterilization is contemplated in the case of a woman.

The question of voluntary sterilization and the question of birth control are closely associated and, aside from the legal angles involved, the physician who may be asked to perform such an operation is confronted with the responsibility of making a decision between surgery as a method of birth control and other measures which can be used to avoid pregnancy.

Even though it might be held in court proceedings that a sterilization operation is justifiable for therapeutic purposes and in instances where childbirth would be detrimental to the health of the wife or might result in the birth of abnormal children, on the other hand, there is a widespread belief that courts or juries would not be very sympathetic to sterilization operations performed merely for "convenience."

The Human Element

If both parties consent to the operation it would seem as if no litigation would take place. On the other hand, the physician can never be sure and it might be at some future time one or both parties would regret their original agreement and might blame the physician for having either urged the operation or consented to perform it.

It is readily seen that this is a moot question. For this reason any physician undertaking a sterilization operation, should be very careful in establishing all possible safeguards. In other words, in the case of a single man or woman, he should have the consent, in writing, of the patient and perhaps have the document witnessed by someone next of kin. In the case of a married man or married woman, the contract of permission should be signed by both the man and wife. Such contracts should set forth clearly the reasons presented by the patient for wanting such an operation. Such documents would be of great value in case of subsequent litigation, and the physician might find himself in a bad way if he could not submit them in his defense.

Recently, in its "Medicine and the Law" department, *The Journal of the AMA* offered these comments regarding sterilization:

"In the absence of specific statutes and court decisions on the subject, the circumstances in which a person can give a valid consent to an operation of this kind are not too clear. While consent is doubtless valid if the operation is necessary to relieve or cure some existing disease or safeguard the life of the patient, the validity of a consent to an operation that is not required for any therapeutic reason nor performed in accord with statutes relating to eugenic sterilization would at least be open to question.

"The law is still not settled, and the question of the physician's legal liability for the performance of an operation to produce sterility in the absence of therapeutic necessity is not clear. In any case, the physician before proceeding with any operation that will produce sterility should obtain from the patient or his parent and from the spouse of a married patient written consent in a form that shows the patient or parent and the spouse have consented with full knowledge of the purpose of the operation and its effects."

Abortion

The same *AMA JOURNAL* article had the following to say regarding abortions:

"Legally abortion has been defined as the 'expulsion of the foetus at so early a stage of uterogestation that it has not acquired the power of sustaining an independent life.' By statute each of the several states has, in substance, provided that the performance of an abortion without therapeutic justification is unlawful. Differences exist, as may be expected, in the language of the several statutes and in the manner of their implementation. For example, some statutes require that the initial determination of therapeutic necessity be supported by the advice of another physician. Other statutes require the advice of two other physicians, and some statutes do not refer to or require consultation. That such consultation is medically and medicolegally desirable, if not mandatory, of course, needs no elaboration. The physician is expected to be familiar with the language of the statute that is in force in his own jurisdiction, and he is legally obliged to observe it.

"The courts are not in accord on the question of whether recovery may be had for injury resulting from negligence in the performance of abortion contrary to law. The weight of authority is that a woman cannot recover damages in such a situation, because her consent to the illegal act should and does constitute a bar to recovery. There are, however, cases that have permitted recovery. The physician who contemplates the performance of an abortion for a therapeutic reason is well advised to obtain appropriate consent, to have consultation, and to maintain adequate records of the case."

Following are three sections of the Revised Code of Ohio relating to the subject of abortions:

"**Section 2901.16**—No person shall prescribe or

administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, unless such miscarriage is necessary to preserve her life, or is advised by two physicians to be necessary for that purpose.

"Whoever violates this section, if the woman either miscarries or dies in consequence thereof, shall be imprisoned not less than one nor more than seven years."

"**Section 2901.17**—In the trial of a person indicted for a violation of Section 2901.16 of the Revised Code, the woman whose miscarriage was procured may be called as a witness by the state. If, being so called, she testifies fully to the cause of such miscarriage, she shall not thereafter be prosecuted for her participation or complicity in such offense.

"On such trial the dying declaration of a woman, who died in consequence of the miscarriage or attempt to produce a miscarriage under investigation, as to the cause and circumstances of such miscarriage or attempt, is admissible."

"**Section 2905.32**—No person shall sell, give away, or keep for sale or gratuitous distribution a secret drug or nostrum purporting to be exclusively for the use of females, or for preventing conception, or for procuring abortion or miscarriage.

"Whoever violates this section shall be fined not more than one thousand dollars or imprisoned not more than six months, or both."

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

American Association of Medical Assistants, Palmer House, Chicago, October 31-November 2.

Central Ohio Heart Association, Scientific Council Session, Columbus, November 5.

Columbus Academy of Medicine, Clinic Day, Columbus, November 1.

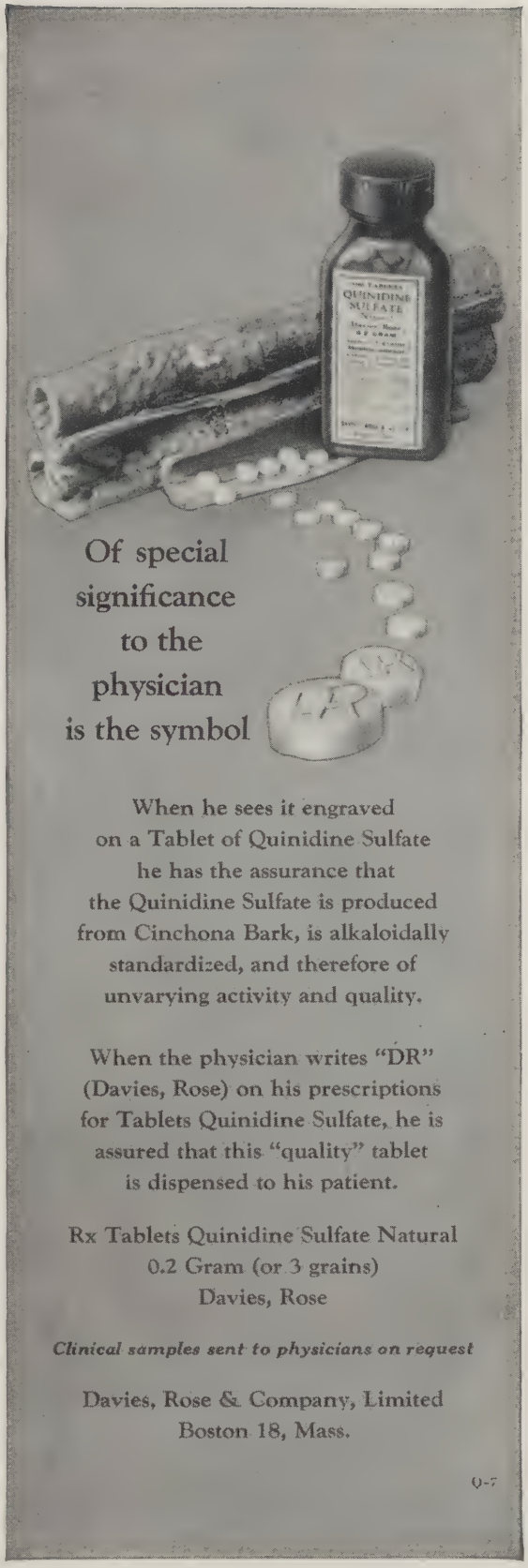
Mississippi Valley Trudeau Society, Dayton, October 17.

National Institute of Arthritis and Metabolic Diseases, Session on Rheumatic Diseases, Ohio State University Campus, Columbus, October 19.

Ohio Hospital Association, Institute on Infections, Columbus, October 15.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

Veterans Administration, Series of Clinical Conferences, Cleveland, Wednesday Evenings.




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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

56-J-018

Ohio's Narcotics Control Act . . .

Stringent Restrictions of the Law in Regard To Handling and Prescribing Narcotics Are Set Forth; Other Provisions of State Act Are Reviewed

OF interest to every physician in practice is the Ohio Narcotics Control Act. Recodification of this act in 1955 and tightening of many of its provisions brought it more nearly into conformity with Federal laws, and made penalties in Ohio equal or in some instances greater than those in surrounding states.

Abstracts of the Narcotics Law are presented herewith for the benefit of physicians who wish to review its provisions. Some parts of the law, not particularly pertinent to physicians, have been omitted from this report.

Penalties apply to minor or technical violations by physicians of the provisions regarding keeping of records, prescribing, dispensing, administering, etc. Drastic penalties are provided for anyone, including a physician, who participates in illicit traffic in narcotics, conspires with others to sell narcotics illegally, unlawfully sells, dispenses or administers narcotics to minors or induces minors to use or traffic in narcotics.

The act is designed to crack down hard on illicit dope peddlers. It imposes only enough restrictions on physicians to make it unpopular and unwise for them to become careless or negligent in handling narcotics.

Following are excerpts from the Narcotics Control Act of Ohio:

Excerpts from Act

Sec. 3719.01. As used in sections 3719.01 to 3719.22, inclusive, of the Revised Code:

(B) "Practitioner" means a person who is licensed in this state to prescribe, dispense, and administer narcotic drugs to a patient or to any animal.

(L) **"Narcotic drugs" means coca leaves, opium, isonipecaine, amidone, isoamidone, ketobemidone, cannabis, and every substance not chemically distinguishable from them and every drug to which the federal laws relating to narcotic drugs may apply.**

(M) "Isonipecaine" means any substance identified chemically as 1-methyl-4-phenyl-piperidine-4-carboxylic acid ethyl ester, or any salt thereof, by whatever trade name designated.

(N) "Amidone" means any substance identified chemically as 4-4-diphenyl-6-dimethylamino-heptanone-3, or any salt thereof, by whatever trade name designated.

(O) "Isoamidone" means any substance identified chemically as 4, 4-diphenyl-5-methyl-6-dimethylaminohexanone-3, or any salt thereof, by whatever trade name designated.

(P) "Keto-bemidone" means any substance identified chemically as 4-(3-hydroxyphenyl)-1-methyl-4-piperidyl ethyl ketone hydrochloride or any salt thereof, by whatever trade name designated.

(R) "Official written order" means an order written on a form provided for that purpose by the United States commissioner of narcotics, under any laws of the United States making provision therefor, if such order forms are authorized and required by federal law.

(S) **"Dispense" means sell, distribute, leave with, give away, dispose of, or deliver.**

(T) "Registry number" means the number assigned to each person registered under the federal narcotic laws.

(U) **"Prescription" means a written or oral order for a narcotic drug for the use of a particular person or a particular animal given by a practitioner in accordance with the regulations promulgated by the United States commissioner of narcotics pursuant to the federal narcotic laws.**

(W) "Nurse" means a person licensed to engage in the practice of nursing in this state.

Sales by Pharmacist

Sec. 3719.05. (A) **A pharmacist may dispense narcotic drugs to any person upon a written or oral prescription given by a practitioner. Each written prescription shall be properly executed, dated, and signed by the person prescribing on the day when issued and bearing the full name and address of the patient for whom, or of the owner of the animal for which, the narcotic drug is dispensed, and the full name, address, and registry number under the federal narcotic laws of the person prescribing. If the prescription be for an animal, it shall state the species of animal for which the drug is prescribed. The pharmacist filling the prescription shall write the date of filling and his own signature on the face of the prescription. The prescription shall be retained on file by the owner of the pharmacy in which it is filled for a period of two years, so as to be readily accessible for inspection by any public officer or employee engaged in the**

enforcement of sections 3719.01 to 3719.22, inclusive, of the Revised Code. Each oral prescription shall be recorded by the pharmacist and such record shall show the name and address of the patient for whom, or of the owner of the animal for which, the narcotic drug is dispensed, the full name, address, and registry number under the federal narcotic laws of the practitioner prescribing, the name of the narcotic drug dispensed, the amount dispensed, and the date when dispensed. Such record shall be retained on file by the owner of the pharmacy in which it is filled for a period of two years. No prescription shall be refilled.

(C) A pharmacist may dispense, upon an official written order to a practitioner in quantities not exceeding one ounce at any one time, aqueous or oleaginous solutions of which the content of narcotic drugs does not exceed a proportion greater than twenty per cent of the complete solution, to be used for medical purposes.

Prescribing and Dispensing

Sec. 3719.06. (A) A practitioner licensed to prescribe, dispense, and administer narcotic drugs to a human being in the course of his professional practice may prescribe by a written or oral prescription, administer, or dispense narcotic drugs, or he may cause the same to be administered under his direction and supervision. Each written prescription shall be dated and signed by the practitioner prescribing on the day when issued and shall bear the full name and address of the person for whom the narcotic drug is prescribed and the full name, address, and registry number under the federal narcotic laws of the person prescribing.

(B) A practitioner licensed to prescribe, dispense, and administer narcotic drugs to an animal in the course of his professional practice and not for use by a human being, may prescribe, by a written or oral prescription, administer, and dispense narcotic drugs or he may cause them to be administered by an assistant or orderly under his direction and supervision. Each written prescription shall be dated and signed by the practitioner prescribing on the day when issued and shall bear the full name and address of the owner of the animal, the species of the animal for which the narcotic drug is prescribed and the full name, address, and registry number under the federal narcotic laws of the practitioner prescribing.

(C) Any person, who has obtained from a practitioner any narcotic drug for administration to a human being or an animal during the absence of such practitioner, shall return to such practitioner any unused portion of such drug,

(Continued on Page 1370)

Cook County
Graduate School of Medicine

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STARTING DATES — FALL, 1958

SURGERY—Surgical Technic, two weeks, Oct. 27, Nov. 10. Surgery of Colon & Rectum, one week, Oct. 27, December 1. Basic Principles in General Surgery, two weeks, Oct. 13. Gallbladder Surgery, three days, Nov. 3. Surgery of Hernia, three days, Nov. 6. General Surgery, two weeks, Nov. 10; one week, Oct. 27. Fractures & Traumatic Surgery, two weeks, Dec. 1. American Board Review Course, two weeks, Nov. 10. Blood Vessel Surgery, one week, Oct. 20.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 13. Vaginal Approach to Pelvic Surgery, one week, Nov. 17. General & Surgical Obstetrics, two weeks, Oct. 27.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3.

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Ten-Day Practical Course in Cystoscopy by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 1.

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FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

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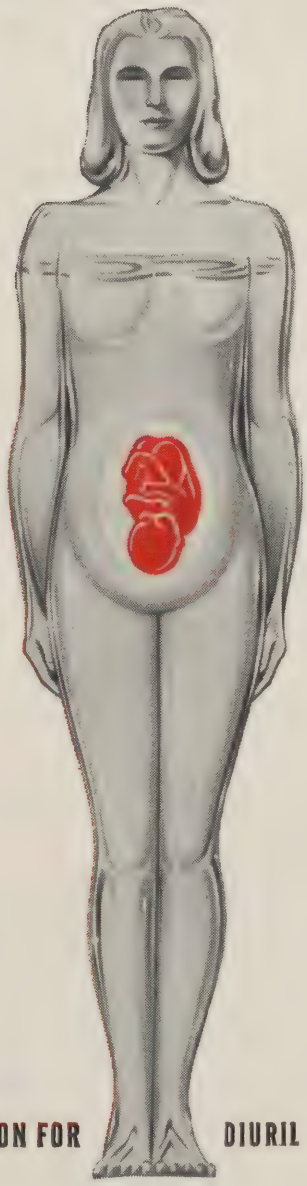
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. caused an excellent diuresis, with reduction of edema, weight, blood pressure, and albuminuria. . . ."



ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

when it is no longer required by such human being or animal.

Keeping of Records

Sec. 3719.07. (A) Every practitoner, or other person who is authorized to administer or use narcotic drugs, shall keep a record of all such drugs received by him, and a record of all such drugs administered, dispensed, or used by him otherwise than by prescription in accordance with the provisions of division (E) of this section. The keeping of a record of the quantity, character, and potency of solutions or other preparations purchased or made up by a practitioner or other person using small quantities of solutions or other preparations of narcotic drugs for local application, and of the dates when purchased or made up, without keeping a record of the amount of such solution or other preparation applied by him to individual patients shall be a sufficient compliance with this division.

No record need be kept of narcotic drugs administered, dispensed, or used in the treatment of any one person or animal, when the amount administered, dispensed, or used for that purpose does not exceed in any forty-eight consecutive hours:

(1) Two grains of opium;

(2) One-half of a grain of morphine or of any of its salts;

(3) Four grains of codeine or of any of its salts;

(4) One-third of a grain of dihydrocodeinone;

(5) A quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

(D) Every person who purchases for resale, or who dispenses narcotic drug preparations exempted by section 3719.15 of the Revised Code shall keep a record showing the quantities and kinds thereof received, dispensed, or disposed of otherwise, in accordance with division (E) of this section.

(E) Every practitioner or other person, except a pharmacist, manufacturer, or wholesaler, authorized to administer or use narcotic drugs shall when the keeping of a record is required by the federal narcotic laws or regulations promulgated by the United States commissioner of narcotics, keep a record of all narcotic drugs received, administered, dispensed, or used which shall contain:

(1) A description of all narcotic drugs received, the quantity of narcotic drugs received, the name and address of the person from whom received, and the date of receipt;

(2) The kind and quantity of narcotic drugs administered, dispensed, or used, the date of administering, dispensing, or using, the name and address of the person to whom, or for whose use, or the owner and species of the animal for which the narcotic drug was administered, dispensed, or used.

Every such record shall be kept for a period of two years and the date of the transaction recorded.

The keeping of a record required by or under the federal narcotic laws, containing substantially the same information as specified in this section, shall constitute compliance with this section.

Every person who purchases for resale or who sells narcotic drug preparations exempted by section 3719.15 of the Revised Code shall keep the record required by or under the federal narcotic law.

Licensing Agency To Be Informed

Sec. 3719.12. On the conviction of a manufacturer, wholesaler, practitioner, pharmacist, or nurse of the violation of sections 3719.01 to 3719.22, inclusive, of the Revised Code a copy of the judgment and sentence of the court or magistrate shall be sent by the clerk of the court, or by the magistrate, to the board or officer by whom such manufacturer, wholesaler, practitioner, pharmacist, or nurse has been licensed or registered to practice his profession or to carry on his business. Such board or officer shall have the power to revoke such license or registration.

Suspension of License

Sec. 3719.121. Any practitioner, nurse, pharmacist, manufacturer, or wholesaler, who is or shall become addicted to the use of narcotic drugs, shall have his license or registration suspended by the board under which he has been licensed or registered until such time as such practitioner, nurse, pharmacist, manufacturer, or wholesaler shall offer satisfactory proof to such board that he is no longer addicted to the use of narcotic drugs.

Inspections

Sec. 3719.13. Prescriptions, orders, and records, required by sections 3719.01 to 3719.22, inclusive, of the Revised Code, and stocks of narcotic drugs, shall be open for inspection only to federal, state, county and municipal officers, whose duty it is to enforce the laws of this state or of the United



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strengthen bodies with needed protein
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Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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States relating to narcotic drugs. No officer having knowledge, by virtue of his office, of any such prescription, order, or record shall divulge such knowledge, except in connection with a prosecution or proceeding in court or before a licensing or registration board or officer, to which prosecution or proceeding the person to whom such prescriptions, orders or records relate is a party.

Exempt Preparations

Sec. 3719.15. Except as specifically provided in sections 3719.01 to 3719.22, inclusive, of the Revised Code such sections shall not apply to the following cases:

(A) Where a practitioner administers or dispenses; or where a pharmacist or owner of a pharmacy sells at retail any medicinal preparation that contains in one fluid ounce, or if a solid or semisolid preparation, in one avoirdupois ounce:

(1) Not more than two grains of opium;

(2) Not more than one quarter of a grain of morphine or of any of its salts;

(3) Not more than one grain of codeine or of any of its salts;

(4) Not more than one-sixth of a grain of dihydrocodeinone;

(5) Not more than one half of a grain of extract of cannabis nor more than one half of a grain of any more potent derivative or preparation of cannabis;

(B) Where a practitioner administers or dispenses; or where a pharmacist sells at retail liniments, ointments, and other preparations, that are susceptible of external use only and that contain narcotic drugs in such combination as prevent their being readily extracted from such liniments, ointments, or preparations, except that such sections shall apply to all liniments, ointments, and other preparations, that contain coca leaves in any quantity or combination.

The medicinal preparation, or the liniment, ointment, or other preparation susceptible of external use only, prescribed, administered, dispensed, or sold, shall contain, in addition to the narcotic drug in it, some drug or drugs conferring upon it medicinal qualities other than those possessed by the narcotic drug alone. Such preparation shall be prescribed, administered, compounded, dispensed, and sold in good faith as a medicine, and not for the purpose of evading such sections.

Limits to Any One Person

Sec. 3719.16. No person shall prescribe, administer, dispense, or sell, under the exemptions of section 3719.15 of the Revised Code to any one person, or for the use of any one person or animal, any preparation included within such section, when he knows, or can by reasonable diligence ascertain, that such prescribing, administering, dispensing, or selling will provide the person to whom or for whose use, or the owner of the animal for the use of which, such preparation is prescribed, administered, dispensed, or sold, within any forty-eight consecutive hours, with more than two grains of opium, or more than one half of a grain of morphine or any of its salts, or more than four grains of codeine or of any of its salts, or more than one third of a grain of dihydrocodeinone, or will provide such person or the owner of such animal, within forty-eight consecutive hours, with more than one preparation exempted by the provisions of section 3719.15 of the Revised Code.

False Statements

Sec. 3719.171. No person shall:

(A) Knowlingly make a false statement in any prescription, order, report, or record, required by sections 3719.01 to 3719.22, inclusive, of the Revised Code;

(B) Make or utter any false or forged prescription or official written order:

(C) Affix any false or forged label to a package or receptacle containing narcotic drugs.



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REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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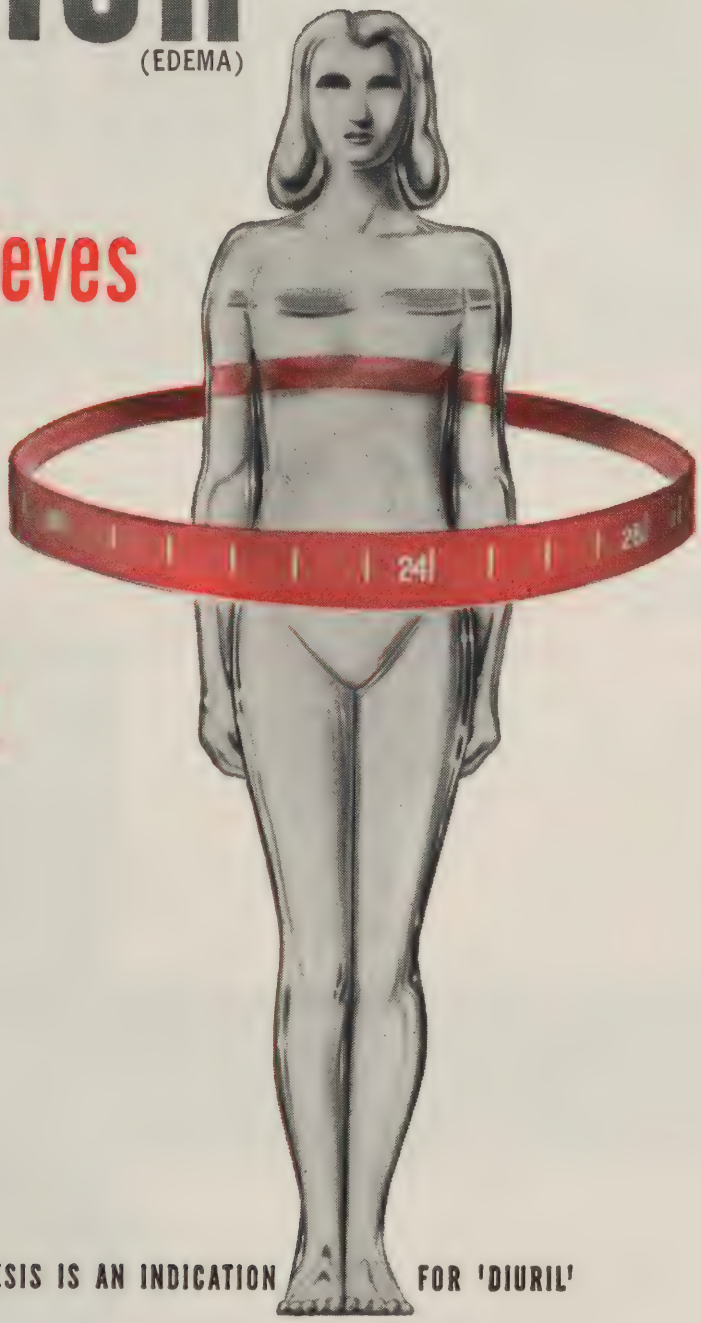
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1. Welsh, A. L., and Ede, M.: J.A.M.A. *166*:158, 1958.
2. Bleiberg, J.: J.M. Soc. New Jersey *53*:37, 1956.
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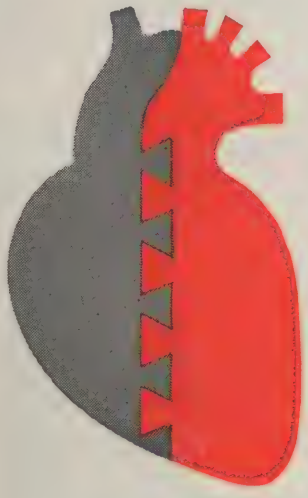
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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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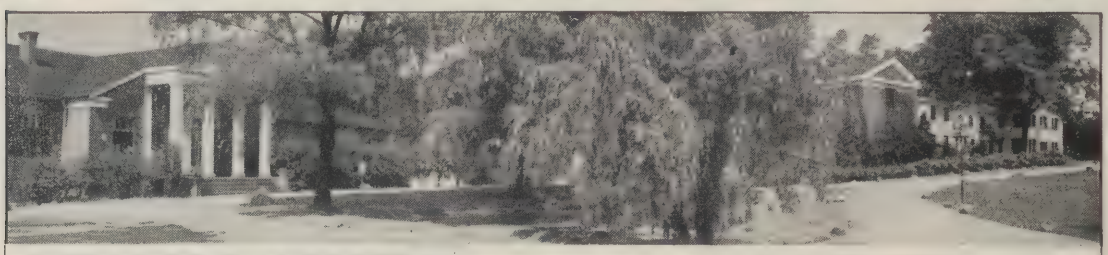
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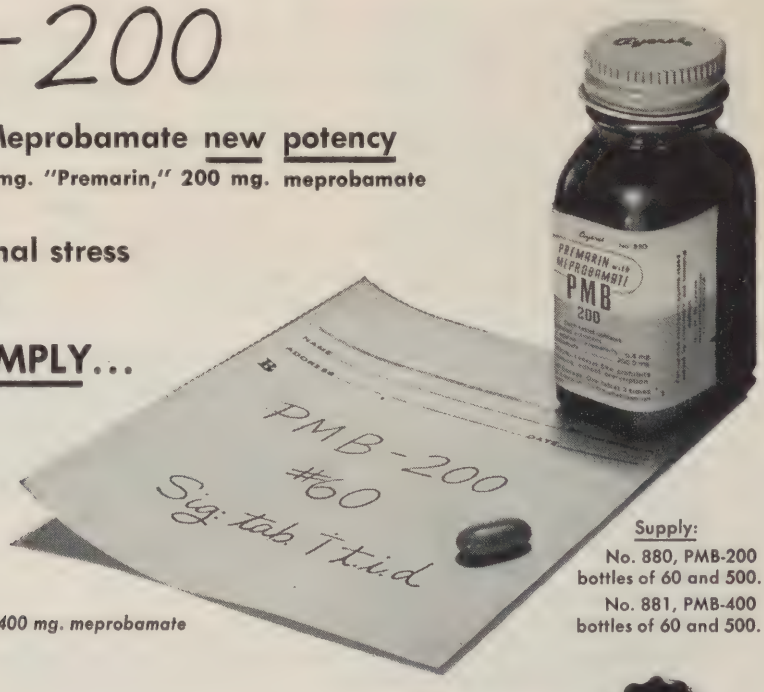
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Two capsules on arising **last all day**
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relieve nervous tension on a *sustained* basis, without between-dose interruption

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2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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References: 1. Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.
2. Goldsmith, J. W.: Minnesota Med. *40*:99 (Feb.) 1957.

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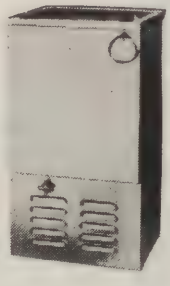
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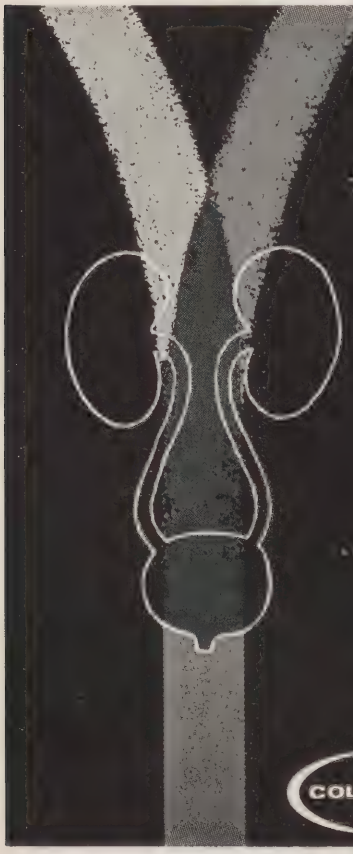
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REFERENCES: (1) Greenblatt, R. H., & Jungck, E. C.: *J.A.M.A.* 166:1461 (Mar. 22) 1958. (2) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956.

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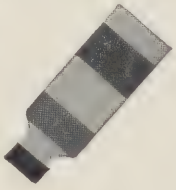
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The Ohio State Medical Journal

Vol. 54 November, 1958 No. 11

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32**:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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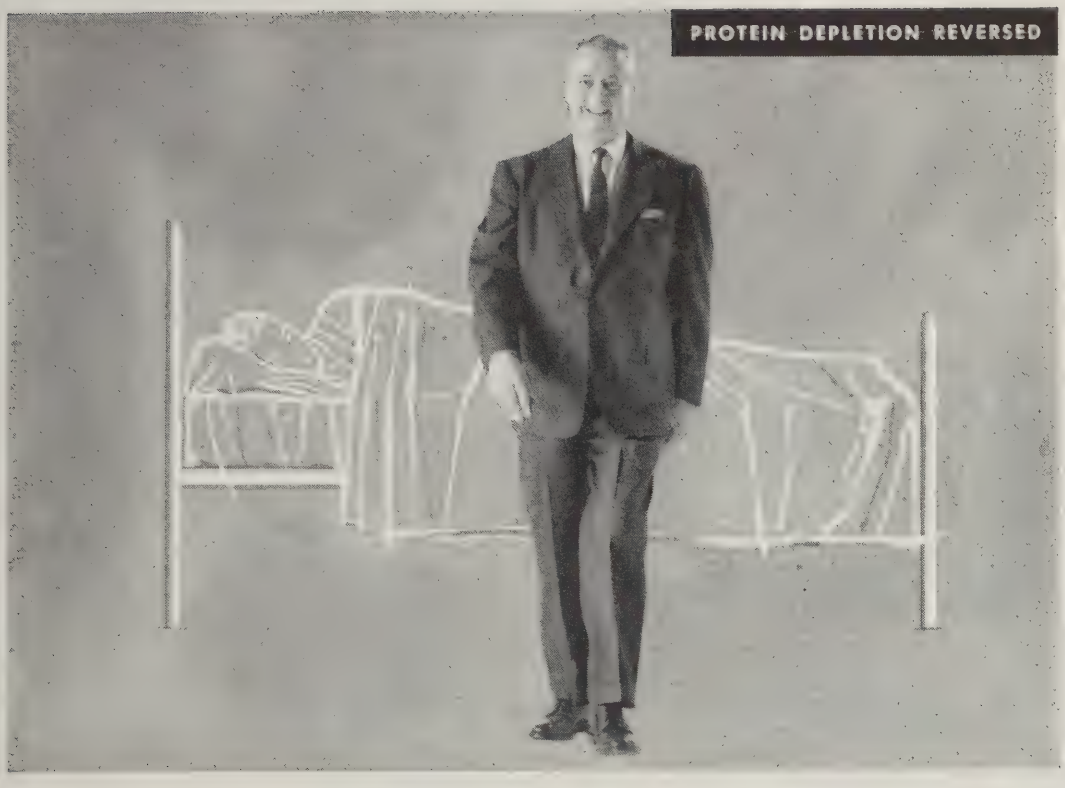
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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Collected Papers of the Mayo Clinic and the Mayo Foundation; 1956, by Richard M. Hewitt, M.D., and staff. (\$12.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Autonomic Imbalance and the Hypothalamus, by Ernst Gellhorn, M. D. (\$8.50, *University of Minnesota Press, Minneapolis 14, Minn.)*

Hormonal Regulation of Energy Metabolism, compiled and edited by Laurance W. Kinsell, M. D. (\$5.25, *C. C. Thomas Publisher, Springfield, Ill.)*

From Sterility to Fertility: A Guide to the Causes and Cure of Childlessness, by Elliot E. Philipp, M. D. (\$4.75, *Philosophical Library, Inc., New York 16, N. Y.)*

Psychological Aspects of Ageing: Proceedings of the Conference on Planning Research, held at Bethesda, Maryland, by John E. Anderson. (2.00, *American Psychological Association, 1333 6th Street, N. W., Washington, D. C.)*

Induced Delusions, The Psychopathy of Freudism, by Coyt H. Campbell, M. D. (\$4.00, *Regent House, 4707 Broadway, Chicago, Illinois.)*

Manual of Pediatric Physical Diagnosis, by Lewis A. Barness, M. D. (\$4.00, *The Year Book Publishers, Inc., Chicago, Illinois.)*

Bedside Diagnosis, by Charles Seward, M. D. (\$5.50, 4th edition, *William & Wilkins Company, Baltimore 2, Maryland.)*

Artificial Insemination in the Human, by A. M. C. M. Schellan, M. D. (\$14.00, *Elsevier Press, Inc., Bank of the Southwest Building, Houston 2, Texas.)*

Book of Health: The Official AMA Book of Health, by W. W. Bauer, M. D. (35¢, A Dell First Edition, compiled from recent articles in **Today's Health,** *Dell Publishing Company, Inc., New York 16, N. Y.)*

The Chronically Ill, by Joseph Fox, Ph. D. (\$3.95, *Philosophical Library, Inc., New York 16, New York.)*

Miracle Drugs in the New Age of Medicine, by Fred Reinfeld. (\$3.95, *Sterling Publishing Company, New York 10, N. Y.)*

Human Blood Coagulation and Its Disorders, by Rosemary Biggs, M. D., and R. G. Macfarlane, M. D. (\$8.50, 2nd edition, *Charles C. Thomas Publisher, Springfield, Illinois.)*

Orthopedics for the General Practitioner, by William E. Kenney, M. D., and Carroll B. Larson, M. D. (\$11.50, 180 illustrations, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

Management of Complications in Eye Surgery, by R. M. Fasanella, M. D., contributed to by 20 authorities. (\$16.00, *W. B. Saunders Company, Philadelphia 5, Pa.)*

The Premature Baby, by V. Mary Crosse. (\$5.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

Introduction to Anesthesia, by Robert D. Dripps, M. D., James E. Eckenhoff, M. D., and Leroy D. Vandam, M. D. (\$4.75, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Dangerous Properties of Industrial Materials, by N. Irving Sax, assisted by five other authorities. (\$22.50, *Reinhold Publishing Company, New York 22, N. Y.)*

Simplified Diet Manual, by the Nutrition Service of the Iowa State Department of Health in cooperation with the Iowa Dietetic Association. (\$1.95, *Iowa State College Press, State Department of Health, Ames, Iowa.)*

The Impact of the Antibiotics on Medicine and Society, (Monograph II), by Iago Galdston, M. D. (\$5.00, *International Universities Press, New York, New York.)*

Adventures in Medical Education, by G. Canby Robinson, M. D. (\$5.00, *Harvard University Press, Cambridge 38, Mass.)*

Body Water in Man, by Maurice B. Strauss, M. D. (\$7.00, *Little, Brown and Company, Boston 6, Mass.)*

Studies in Human Ecology, A Series of Lectures given at the Anthropological Society in Washington, *(Pan American Union of Washington D. C.)*

The Biology of Ageing, by W. P. Yappe and G. H. Bowme. (\$4.25, *Hafner Publishing Company, New York 3, New York.)*

Peripheral Circulation in Health and Disease, by Walter Redisch, M. D., and Francisco F. Tangco, M. D. (\$7.75, *Grune & Stratton, New York 16, New York.)*

Management of the Patient with Headache, by Perry S. MacNeal, Bernard J. Alpers, M. D.,

and William R. O'Brien. ($3.50, *Lea & Febiger, Philadelphia 6, Pa.)*

Prescription for Survival, by Brock Chisholm. ($2.50, *Columbia University Press, New York 27, New York.)*

Chronic Illness in a Large City, by the Commission on Chronic Illness. ($8.00, *Harvard University Press, Cambridge 38, Mass.)*

Doctors in the Air, by Wing Commander Robert Maycock. ($3.75, *Thomas Nelson & Sons, New York 17, New York.)*

The Function of the Ureter and Renal Pelvis, by Frederik Kiil, M. D. ($7.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Symposium on Diseases and Surgery of the Lens, by George M. Haik, M. D. ($10.50, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

The Electrocardiogram, by Louis H. Sigler, M. D. ($8.75, second edition, *Grune & Stratton, New York 16, N. Y.*

Hormones in Blood; Ciba Foundation Colloquia on Endocrinology: Volume XI, by G. E. W. Wolstenholme and Elaine C. P. Millar. ($9.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

The Principles and Practice of Diathermy, by Bryan O. Scott, D. Phys. Med. ($5.00, *Charles C. Thomas Publisher, Springfield, Illinois.)*

Bone Diseases in Medical Practice, by I. Snapper. ($15.00, *Grune & Stratton, Inc., New York 16, New York.)*

Clinical Orthopaedics, by Anthony F. De Palma, M. D., with the assistance of associate editors. ($7.50, Volume 10, *J. B. Lippincott Company, Philadelphia 5, Pa.)*

A Mental Health Handbook, by Ian Skottowe, M. D. ($5.00, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

An Introduction to Dermatology, by G. H. Percival, M. D. ($9.00, *Williams and Wilkins, Baltimore 2, Maryland.)*

Cortisone Therapy: Mainly applied to the rheumatic diseases, by J. H. H. Glyn, M. D. ($10.00 *Philosophical Library, Inc., New York 16, New York.)*

The Infantile Cerebral Palsies, by Eirene Collis, W. R. F. Collis, William Dunham, L. T. Hilliard and David Lawson. ($3.00, *C. C. Thomas Publisher, Springfield, Illinois.)*

The Story of Peptic Ulcer: Dawn for Depressed and Disappointed Dyspeptics, by Richard D. Tonkin, M. D. ($2.25, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Deafness, Mutism and Mental Deficiency in Children, by Louis Minski, M. D. ($3.75, *Philosophical Library, New York 16, New York.)*

Neomycin: Its Nature and Practical Application, by Selman A. Waksman. ($5.00, published for the Institute of Microbiology, Rutgers University, by *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Textbook of Medical Treatment, by D. M. Dunlop, M. D., Sir Stanley Davidson, M. D., and S. Alstead, M. D. ($11.00, 7th edition, U. S. Distributors, *Williams & Wilkins Co., Baltimore 2, Maryland.)*

The Development and Disorders of Speech in Childhood, by Muriel E. Morley, F.C.S.T., foreword by Professor Donald Court, M. D. ($9.00, *E. & S. Livingstone, Ltd. of Edinburgh;* U. S. distributors: *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Aids to Materia Medica and Therapeutics, by J. W. Hadgraft. ($3.25, 5th edition, *Bailliere, Tindall & Cox, London;* U. S. distributors, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

May's Manual of the Diseases of the Eye, revised by Charles A. Perera, M. D. ($6.00, 22nd edition, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Arthritis Can Be Cured, by Bernhard Aschner, M. D. ($3.95, *Julian Press, 80 E. 11th St., New York 3, New York)*

Hemophilia and Hemophilioid Diseases, A Symposium arranged by the National Hemophilia Foundation, by Kenneth N. Brinkhous, M. D. ($7.50, *University of North Carolina Press, Chapel Hill, North Carolina.)*

Hepatitis Frontiers, by Frank W. Hartman, M. D., and his associates at the Henry Ford Hospital. ($12.50, *Little, Brown and Company, Boston 6, Mass.)*

Heart Sounds, Cardiac Pulsations, and Coronary Disease, by William Dock, M. D. ($2.50, *University of Kansas Press, Lawrence, Kansas.)*

Psychosomatic Ophthalmology, by T. F. Schlaegel, Jr., M. D. ($11.00, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Chronic Schizophrenia, by Thomas Freeman, John L. Cameron and Andrew McGhie. ($4.00, *International Universities Press, New York 11, New York.)*

Handbook of Treatment of Acute Poisoning, by E. H. Bensley, M. D., and G. E. Joron, M. D. ($4.00, Second edition, *E. & S. Livingstone LTD,* distributed by *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Investigator

after investigator reports

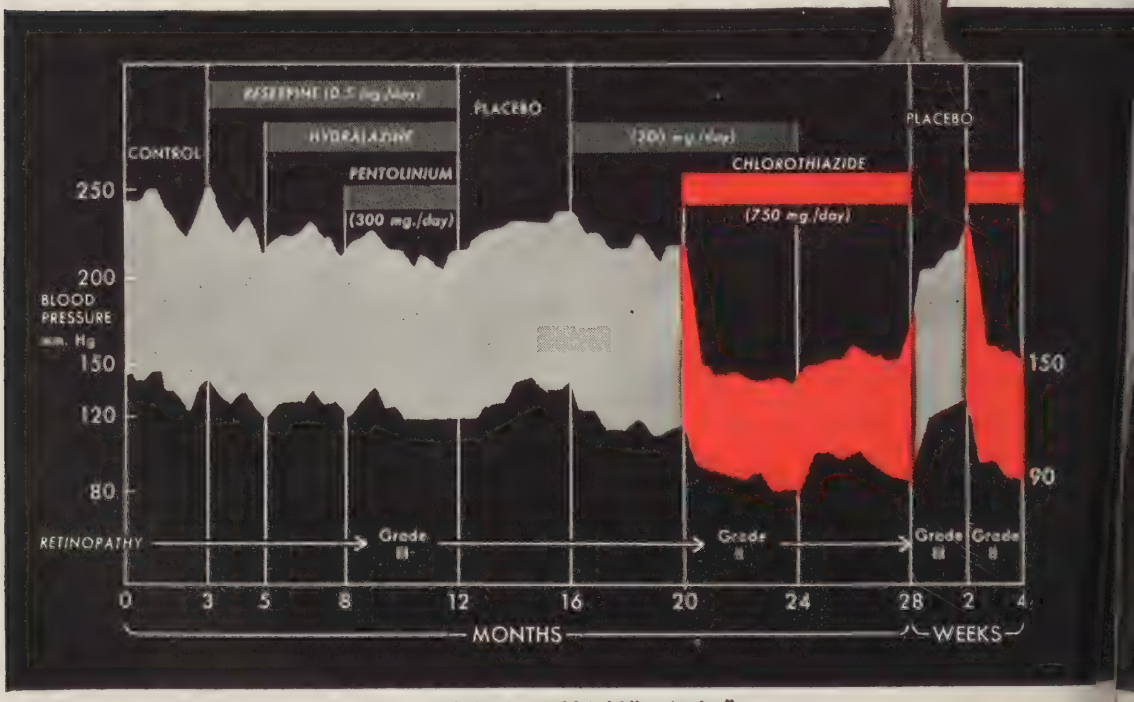
Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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You and Your Public . . .

Motivational Researcher Lists Five Keys To Doctor-Patient Relationship

WHY do women buy more in supermarkets? What urge makes motorists want to speed past red automobiles? What type of candidate attracts voters?

The rapidly developing field of motivational research concerns itself with the answers to many questions such as these. It all boils down to "What makes John Doe Tick?" The motivation men are coming up with some surprising answers —and that's why doctors may find it is of interest when a motivation expert offers some keys to well-adjusted physician-patient relationship.

In this instance, Ernest Dichter, Ph. D., president of the Institute for Motivational Research, New York City, is the expert. He has guided motivation studies concerned with practical steps the medical profession can take to improve relationships. He offers for physicians the following five keys, which are well worth studying:

1. **Relax and learn to accept yourself.** The medical profession can do much to help the doctor resolve his own conflicts about his role. Through lectures and pamphlets the doctor can be made to understand that he is, after all, a person with material aspirations and needs as well as with ideals.

2. **Recognize the patient's right to information.** People are more sophisticated today than they once were, and they ask a great many more questions. They have read medical articles, they recognize some of the terminology, and they are unwilling to accept the unquestionable authority of the doctor. The doctor who treats his patients as if they are intelligent, aware people with a perfect right to understand the diagnosis and the treatment prescribed will find his patients responding with acceptance and with loyalty.

3. **Establish a continuous relationship.** In many areas doctors have begun to recognize the need for a continuous relationship not simply treatment when the patient is ill, but regular examinations to maintain good health. This is a sensible practice from a physical point of view and is psychologically correct as well, since it is an indication on the part of the doctor of his constant interest in his patients' welfare. A simple reminder that it is time for a check-up should be a part of every doctor's office procedure.

4. **Meet the fee question honestly.** Remember that patients resent fees which are tied to the saving of a life or the restoration of their health. To them this approach smacks of "blackmail." Patients also resent being billed on the basis of whatever "the traffic will bear." They want standard fees which are the same for everyone. They accept the doctor's need to make a living. They do not, however, accept the same increased costs for health and medical care that they accept for housing, for clothing, for food, for entertainment. They expect and get more from their doctor in terms of medical care, but they still resent increased costs. It is here that a general educational program is needed, and the medical profession could do much to show the public why increased costs for medical care are necessary, and actually how slight they have been compared to other increases.

5. **Recognize your community role.** Despite the changes which have occurred in medicine, the role of the doctor in the community is still a leading one. The doctor is a figure of importance. People consider him a community leader. They tend to judge him by his degree of interest in his community and also by such symbols of status as the kind of car he drives, the kind of home he lives in, etc. The doctor must decide for himself the kind of public image of himself he wishes to create. To create the proper image in terms of his practice and his community, he must recognize that he is a public figure, especially in a small community; and he must also recognize the standards and the needs of his patients.

This list of practical guides can be greatly enlarged, and can prove immensely helpful to the future of the medical profession if doctors can consider their role a segment of a much larger frame of reference, that of American democracy. Within this larger framework questions of authority versus equality and partnership become clear and understandable. These guides are steps in the growth from immaturity to maturity. More mature doctors will produce more mature patients, and both, of course, contribute to a greater maturity in every area of American life.



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Hospital practice of infant feeding

Self-regulated schedules

The newborn may become a feeding problem if the formula is excessive or if he is awakened to be fed forcefully.

The young infant may balk at new food or procedure. The older infant, devoted to his bottle, may resent weaning—it takes a certain readiness for weaning to make the change agreeable. Later, the infant may become somewhat independent and arbitrary—what he enjoyed yesterday he rejects today.

WHOLE MILK FORMULAS

Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760
12	32	9	0	8	5	640

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	5	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812
7	14	21	3	7	5	796
8	15	20	2	7	5	780
10	16	16	1	8	4	764
12	16	16	0	8	4	704

When a feeding problem is in the making, sensible decorum will solve it. Nature invites infant feeding cooperation through hunger. If hunger is appeased on demand rather than by clock there will be fewer problems—the baby is the best judge of when he wants food and how much.

Feeding must be adapted to the infant individually to make it a pleasurable experience. This is the current objective in successful infant feeding formulated for normal infants in the charts below:

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Usual adult dose is 250 mg. four times daily. Dosage for children may be reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also available in tasty, cinnamon-flavored oral suspension; comes in 75-cc. bottles.

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SAFETY FIRST

IN ANTIBIOTIC THERAPY



You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Newspaper for Physicians

The *AMA News,* which made its debut with the September 22 issue, is a fortnightly newspaper based on a new concept of reporting news of interest to America's physicians.

It was conceived after more than a year of inquiries, research and personal interviews with doctors. It is designed to fill the doctor's need for news of the medical community. It is edited in easy-to-read style for the busy physician.

Editorial content is non-technical, featuring articles of special interest to doctors in the medico-economic and socio-economic fields. It reflects all aspects of a physician's life, his work, his problems.

The News concentrates on articles not now carried in other AMA Journals. For example, scientific reports are news stories, many of them calling attention to detailed articles in *The Journal of the American Medical Association* and other publications.

Its purpose is practical—to help doctors figure out the day-to-day problems that go with practicing medicine, bettering the health of the community and the profession of medicine.

New Field Staff Member

Dr. M. Eleanor Blish of Houston, Texas, has been appointed a member of the field staff of AMA's Council on Medical Education and Hospitals. Dr. Blish has been in the private practice of pediatrics in Houston since 1944 and on the staffs of Baylor University College of Medicine and Children's Clinic at Houston Tuberculosis Hospital.

Misleading Advertising

Lending its support to a campaign to curtail offensive or misleading advertising of over-the-counter medications, the American Medical Association has become a member of the National Better Business Bureau.

NBBB will coordinate the work of voluntary organizations seeking to eliminate objectionable advertisements of some over-the-counter medical products.

The AMA organized a meeting in May, 1958, of drug manufacturers, advertising agencies, and radio, television, newspaper and magazine representatives. This group suggested that NBBB coordinate the voluntary program.

Immediate support for the program came from Richard L. Scheidker, senior vice-president of the American Association of Advertising Agencies, who told AMA, "We stand ready to work with you in any way that we can in the further development of a cooperative program."

Future Meetings

AMA's Board of Trustees approved Denver as host city for the association's 1961 clinical meeting. The 1959 session will be held in Dallas, the 1960 meeting in Washington, D. C.

World-Wide Qualifications

The first world-wide American Medical Qualification Examination was held Sept. 23 in 35 foreign countries.

Dr. Dean F. Smiley, executive director of the Educational Council for Foreign Medical Graduates, said the program seeks to provide a common denominator for examinations in more than 600 foreign medical schools.

Applications to take the exam have been filed by 1,136 persons.

The examination follows a round-the-world trip by Dr. John P. Hubbard, professor of Preventive Medicine at the University of Pennsylvania, to complete arrangements with proctors.

ECFMG opened its office in October, 1957, at 1710 Orrington Ave., Evanston, Ill., and gave the first examination to 298 foreign applicants with U. S. addresses in March, 1958. Examinations will be given twice a year, in Spring and Fall.

ECFMG is sponsored by American Hospital Assn., American Medical Assn., Association of American Medical Colleges, and Federation of State Medical Boards of the United States.

Reservations for Minneapolis

Physicians who have not done so already should make hotel reservations in Minneapolis for the coming 12th AMA Clinical Meeting, December 2 - 5. Blanks giving prevailing rates in leading Minneapolis hotels together with a blank to be sent to the housing bureau are appearing in current issues of the *AMA News* and *The Journal of the AMA.*

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Supplied: 200 mg. capsules, bottles of 30.

1. Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.
2. Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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*Finnerty, F. A. Jr.: New York State J. Med. 57:2957 (Sept. 15) 1957.

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★ results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

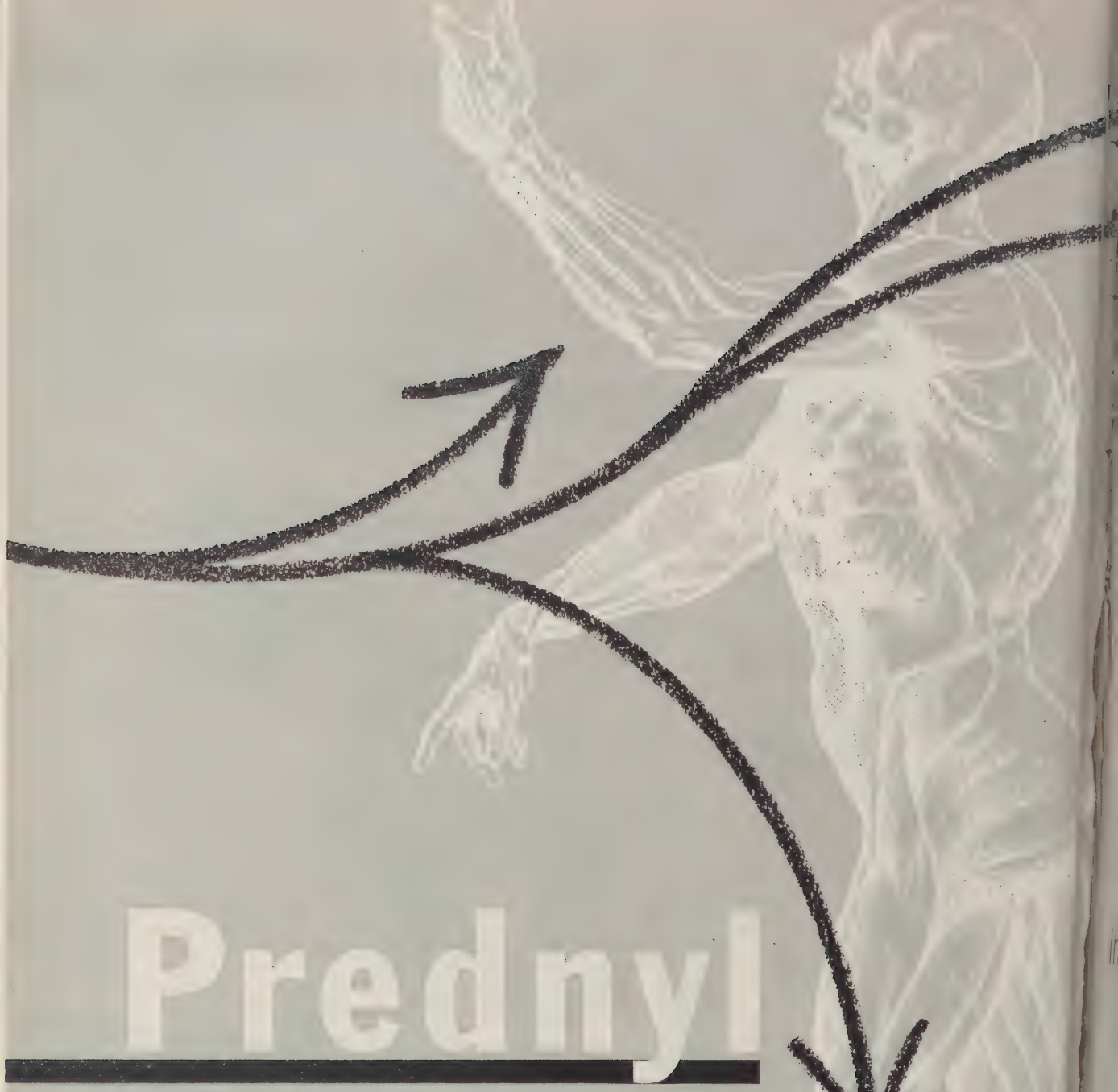
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Usual adult dose: One or two capsule tablets at bedtime. Bottles of 30 and 100.

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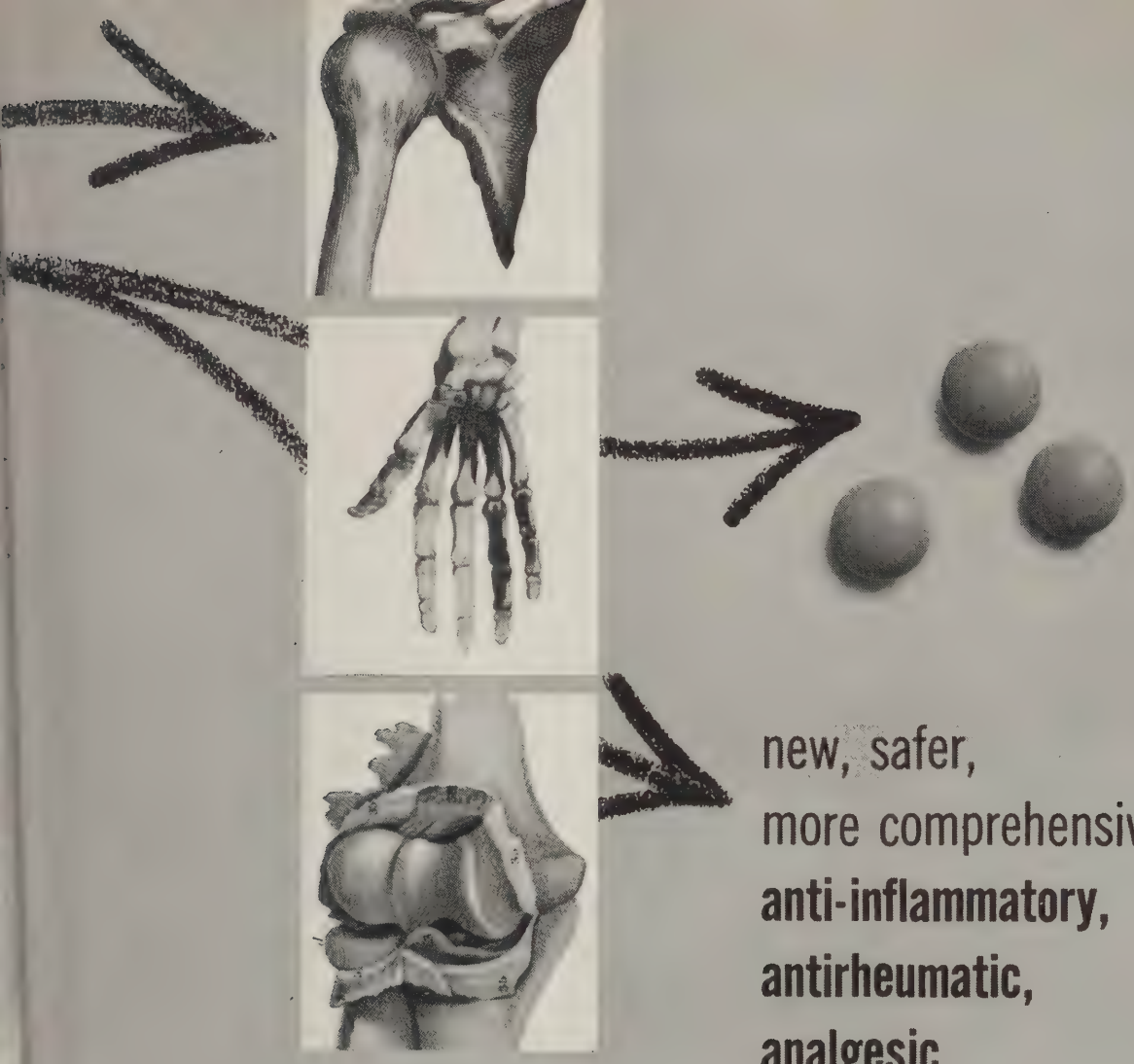
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diagnosis: **hypertension, moderate to severe**

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because immediate lowering of blood pressure is imperative

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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N.J.*

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

The Army Medical Service has activated a new Research and Development Command, with headquarters in Washington. It will serve as the focal point of the Army Medical Service's world-wide program which seeks to provide better preventive medicine measures and more effective and more rapid treatment techniques.

* * *

AMA and allied groups won an important administrative victory in inducing the Post Office Department to rescind a move to ban airmail shipments of etiological disease agents as a protection for crews and passengers. U. S. Public Service's new requirements for packaging such agents was a major factor in getting ban dropped.

* * *

HEW Secretary Flemming reports 43 stations in the states and territories are measuring radioactivity, 45 are testing water and nine are sampling milk. Feed samples packed in 1945 have been collected to gather data on radioactivity changes since that year in which the first nuclear test was held.

* * *

National Institute of Dental Research reports "no significant differences" attributable to fluoride intake could be found in microscopic examination of 99 bones from 37 persons who had drunk for years water containing 1 to 4 ppm. fluoride and bones of 33 controls from areas where water had less than 0.5 ppm.

* * *

Budget Bureau reports OASI and disability payments for the last year at $9.49 billion, with receipts estimated at $8.35 billion, which is $1.14-billion under payments. This difference is expected to be offset by increase in tax rates January 1, 1960.

* * *

United Mine Workers Welfare and Retirement Fund's annual report claims $1,448,909 (2.4 per cent) over previous year in total cost of hospital and medical care, "notwithstanding the sharp increase in such costs throughout the nation."

VA reports development of a device enabling the blind to "read" ordinary printing. An instrument focuses a light beam on the printing and from the printing produces a pattern of musical chords. A blind person trained to interpret the sounds as words and letters, VA says, will have a reading speed of 15 to 30 words a minute.

* * *

National Institutes of Health allocated $42,-665,767 in research grants and fellowships during July and August, representing 2,793 awards. National Heart Institute will administer 588 of the research awards, totalling $8,777,094.

* * *

Public Health Service, following request of National Conference on Nursing Homes for Aged and Association of State and Territorial Health Officers, is designing model legislation and regulations for nursing homes and homes for the aged, which would serve as guide to states and territories interested in revising their laws and rules.

* * *

Latest figures show Hill-Burton projects have passed 4,000 mark. Since 1946, estimated cost of 4,035 approved projects totals $3,373,252,068, of which Federal share is $1,042,108,206. This represents, among other facilities, an increase of 173,059 hospital beds.

* * *

VA is accepting bids for $20 million, 1,000-bed neuro-psychiatric hospital to be erected in Brecksville, Ohio, adjacent to Cleveland. Plans call for following square footage: 139,478 for general medical-surgical-administration building; 123,191 for admission and treatment building; 52,145 each for two continued treatment buildings, and 73,174 for disturbed patients' building.

* * *

Scientists hope to get answers to puzzle of never-measured role of gravity in life's processes by placing 5,000 yeast cells in a satellite to be fired into orbit this fall. Growth of the yeast will be measured for clews to biological effects of weightlessness, cosmic radiation and other space phenomena.



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Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Adult Dosage: one teaspoonful q. 6 h. May be habit-forming.
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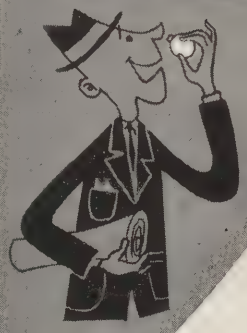
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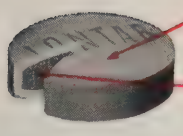
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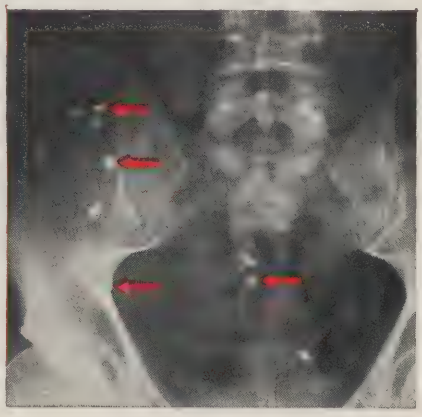
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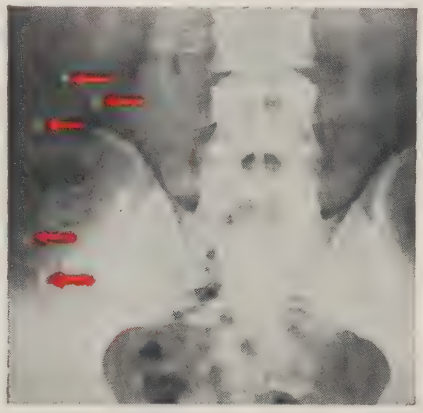
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



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8 hours Lontabs are still visible as substance of core continues to be released.



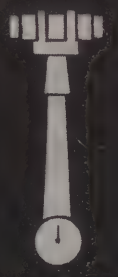
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l-Lysine HCl	300 mg.
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Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NEW OSMA POLICY SETS SPECIFIC ETHICAL GUIDELINES

Each member of the Association received with the October *OSMAgram,* a booklet in which appeared the statement by The Council on the unauthorized practice of medicine by corporations, and others, adopted on June 8, 1958.

This was distributed for the guidance of the membership and to assist county medical societies in dealing with local problems of this nature.

Commenting on this the *Cincinnati Journal of Medicine* offered the following pertinent advice:

"The action taken by the Ohio State Medical Association is timely because it tends to establish a specific policy for physicians when either the unauthorized practice of medicine is involved or it is necessary to clarify the procedure in billing patients. Physicians have expressed concern over the latter wherein it is assumed that either a hospital, corporation, third party pay group, or unauthorized person has the right to make a charge for services that can be rendered only by the physician. The State of Ohio, through legal enactment, has placed the responsibility of the treatment of patients in the hands of the medical profession.

"Under the announced policy of the Ohio State Medical Association, the physician's culpability for unethical practice is specifically outlined. It would be well for physicians to review their relationship with hospitals, corporations, third party pay group, or other lay persons to establish their practice on sound, ethical principles. In the days to come, there will be much discussion about corporate, panel, and unauthorized practice of medicine."

JOIN THE PARADE OF AMEF CONTRIBUTORS

Four thousand Ohio physicians can't be wrong!

Approximately that's the number who contributed over $165,000 for medical education in 1957, either through the American Medical Education Foundation or directly to Alumni Funds.

Presumably most of these proponents of the present system of medical education will contribute to the cause again this year—1958.

They invite their colleagues to join them in the 1958 campaign which began October 1. Somewhere on your desk, if you haven't already used it, is a postpaid envelope addressed to AMEF. Fill out your check and mail it today.

You may prefer to make your donation to the Alumni Fund of your own medical school. If you wish you may earmark your AMEF contribution for a particular school. In either case, DO IT NOW.

The AMEF address is 535 N. Dearborn St., Chicago, Ill.—just in case you have misplaced it.

FIRING THE BULLETS IS A LOCAL JOB

The San Francisco County Medical Society claims the field of medical public relations is primarily a local problem and responsibility. Moreover, it states that the AMA and the state societies should streamline their PR activities and not insist on "package programs," leaving it to local areas to tailor PR work to local needs, with national and state help, if necessary.

With all of this we heartily agree. The state society should act as a clearing house on PR and a source of PR material and hunches. The firing-line job has to be done locally.

That being the case, the local medical society has a serious responsibility and challenge. If it wants to do the job in its own way, that's fine—providing it gets the job done.

SOME PUBLIC HEALTH FACTS AND COMMENTS

Four factual statements in a review of public health activities in Ohio for the year 1957, published by the Ohio Department of Health, are worthy of special comment.

* * *

At the close of 1957 there were more full-time, qualified health districts (69) than part-time, unqualified, (63). Altogether, 83.5 per cent of the state's population is now being served by competent, full-time health departments.

Comment No. 1: Isn't it time for the 16.5 per cent of the population which is being served by unqualified, part-time health departments to do something about this? Do they know that they are playing with fire in not bringing their health department up to a qualified status?

* * *

During 1957, the total amount appropriated for local health departments increased $483,000, the total being $11,568,376—a 4.4 per cent increase.

Comment No. 2: The package picture appears good but what about the 44 health districts which appropriated less in 1957 than in the previous

Low Dosage KYNEX* for G.U. Infections

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Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

*Reg. U.S. Pat. Off.

year? That doesn't appear to be in keeping with the times which demand more and better public health activities.

* * *

During 1957, Ohio's financial support of the Ohio Department of Health decreased. In fact, 39 per cent of the ODH's operating fund in 1957 was derived from Federal sources. This was a 6 per cent increase—a reversal of the pattern of the four previous years.

Comment No. 3: Let's don't get back into the old rut of letting the Federal Government do a job which the people of Ohio ought to be doing. The trend was changed a few years back. Let's get back on the beam.

* * *

Total spent on public health services in Ohio in 1957—state and local—was $15,618,506, an increase of $1.5 million over 1956 and a per capita expenditure of $1.70, up 6 cents from the preceding year.

Comment No. 4: Shows progress but still not good enough for a growing, thriving state like Ohio.

HOW WELL DO YOU KNOW YOUR SYMBOLS?

Do you know what the official symbol of the AMA is and what it means?

The official symbol of the AMA adopted in 1910 is the staff of Aesculapius, composed of a rod encircled by a single serpent. The knots in the staff are supposed to represent the "knotty" problems of medicine. The serpent typifies wisdom. The serpent is also a symbol of healing, since it sloughs off its skin periodically, and thus, symbolically as well as actually, renews its life. Scarlet and gold colors are employed. In the days of alchemy the elixir of life was a red tincture and the key of wisdom a red powder. The gold represents the sun, long regarded as a healing influence.

In ancient mythology, Aesculapius—the son of Apollo and the nymph Coronis—was the god of medicine or healing. The Greeks called him Asklepios, the Romans Aesculapius.

One legend has it that Aesculapius was attending Glaucus when the latter was struck dead by a thunderbolt. When a serpent crept into the room where the man lay, Aesculapius killed it with his staff. Another serpent entered the room and put herbs at the mouth of the first serpent which was then brought back to life. Aesculapius then revived Glaucus with the same herb. Alarmed that Hades was being depopulated, Pluto requested Jupiter to destroy the great doctor with a thunderbolt. At Apollo's request, however, Aesculapius was made immortal and placed among the stars in the southern heavens as Ophiuchus, the snake bearer.

The sacred snakes became synonymous with the god of healing, and the Aesculapian staff was invariably connected with medicine. Temples were erected throughout the ancient world. Aesculapius usually is depicted standing in a long flowing toga with his right hand clasping the staff along which a single serpent twines its way upward.

CLEANUP OF TV "DOCTORS" BADLY NEEDED—AND PROMPTLY

Most physicians, in our opinion, will say a fervent "amen" to the following editorial published by the *New York Times*. The housekeeping job suggested won't be easy to accomplish, but it certainly should be worth the try. Said the *Times*.

"The New York State Medical Society should be commended for adopting a resolution that calls on the American Medical Association to make further efforts to stop the abuse of the word 'doctors' on radio and television commercials. We hope that some pressure can be brought to oblige the networks and their sponsors to do some badly needed housecleaning.

"What is coming over the air now is an insult to the intelligence of the listener and viewer, a slur on the medical profession and an outright danger to the gullible. Any studio announcer can put on a white coat and solemnly declare that 'science shows.' Outrageous and nauseating charts of what purports to be the human anatomy are paraded under the heading of 'clinical tests prove.' And always there are those 'four out of five doctors' who agree to something. And always there is the nostrum that is twice as fast, or three times better, or satisfaction guaranteed or money back.

"There has been some minor straightening out of the cigarette advertising (although it still hasn't got around to grammar) and the cosmetic advertising is usually exaggerated and objectionable rather than dangerous. But the patent medicine show still goes on full blast. Most of the products are probably harmless enough, in all conscience. But it is always possible that some misguided persons will be impressed by the TV 'doctors' and go to patent medicine instead of to a real doctor.

"It is a sorry commentary on our enlightenment when the old 'snake oil' technique can be used on millions of persons to make millions of dollars in profits. Some of the advertising is so obviously false and unscrupulous, even if it happens to stay within the letter of the law, that remedial measures must be taken. It will be better for all concerned if they are taken by the industry itself rather than by government. It is high time to take those phony 'doctors' off the air."

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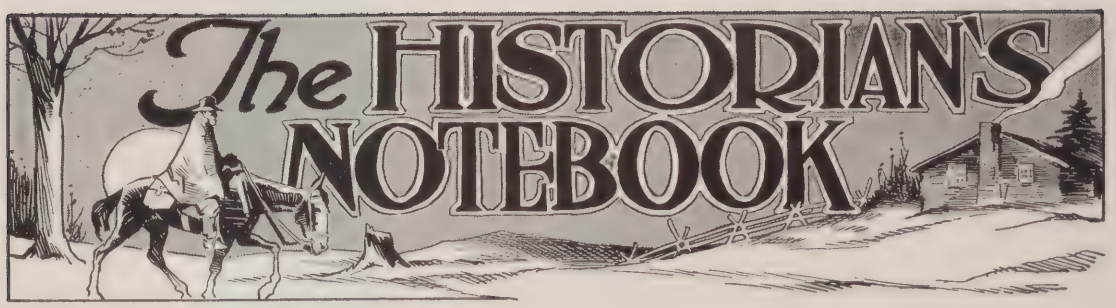
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First Physician Settled in Mansfield, Ohio, in 1815

ELIZABETH REED, M. D.

THE War of 1812 and its constant threat of Indian raids discouraged the migration of new settlers to Richland County. During that period the nearest available physicians were Drs. Irvine and Burr at Mt. Vernon.

The end of the war, in 1815, brought the first two doctors to the county, one to each of the major settlements (Mansfield and Newville). Both were apparently above the average of the physicians of a day when there were few medical graduates and the majority of the "doctors" had at best a three-year apprenticeship with a practicing physician.

This consisted of helping care for the doctor's horses, sweeping out his office, and delivering his pills and powders. In return the student was permitted to read the medical books and was given some instruction in "bleeding," diagnosis, "pill-rolling," and the primitive surgery of the day. It was even possible to buy a "medical book" of which the last page was a diploma. The purchaser read the book; wrote his name on the diploma—and was ready for patients.

Father Was Pastor

Dr. Royal Powers was Mansfield's first physician. His father was a pioneer Baptist preacher in Western New York State; and his red-haired schoolteacher sister Abigail in 1826 married Millard Fillmore, later President of the U. S. Dr. Powers tore down the historic first cabin of Mansfield and erected a frame building of about 18 by 26 feet.

Here he "swung his shingle, kept a few drugs and practiced medicine," on the site of the present H. L. Reed store. Dr. Powers remained in Mansfield a few months and moved north to Huron County where he and his brother laid out the town of New Haven. He opened a general store there and became a fairly prosperous merchant.

Dr. Robert Irvine located just east of Newville, also in 1815; and was the county's only physician from Dr. Powers' departure till 1818. He was born in Ireland in 1764; was a cousin to the Earls of Belmore and Enniskillen, and was descended from an officer in King William's army at the Battle of the Boyne (1690).

After graduation in Medicine at Trinity College, Dublin, he brought his new bride to America in 1787. He located first in Western Pennsylvania on the advice of his uncle, Gen. William Irvine (American commander at Fort Pitt during the Revolution). In 1811 he followed the pioneers to Mt. Vernon and there opened his own drug-store. This was quite usual in the early days when it required four to five months to get drugs ordered and shipped over the mountains from Philadelphia.

Life Too Harsh

Dr. Irvine practiced medicine in Richland County for about five years. The absence of roads and bridges and the long distances between patients proved discouraging to a man in his 50's. He said, "This Ohio country is too uncivilized," and returned to Mercer County, Pa., where he died in 1826. Like most of the very early physicians he was interested in land speculation; and his children inherited the western half of Mercer County.

Medical fees were remarkably low at this period.

The Author

● **Dr. Reed, Butler, Ohio, is in general practice there. Her hobby has always been Medical History.**

Reprinted from the Sesquicentennial Edition of the *Mansfield News-Journal*, Mansfield, Ohio, July 13, 1958.

Dr. Daniel Drake of Cincinnati, founder of the first medical school in Ohio, quotes examples:—Medicines, 25 cents to $1; bleeding, 25 cents; sitting up all night with a patient, $1; Visits, 25 cents per mile—half being deducted and the other half paid in horsefeed or food for the doctor's family. There was almost no money on the frontier and what there was went to the tax collector. Thus most of our early physicians, like Abijah Beach, M. D., who came to Bellville in 1826, were forced to combine various mercantile and land speculations with their medical practice.

Dr. Beach was very successful. In 1857 he made an extensive tour of the hospitals of Europe and in 1868 opened his own hospital in Bellville (The County's first!) After 1877 he retired from medicine and operated "a large grocery and notions store" in Bellville.

Dr. Moore B. Bradley was probably the second physician of Mansfield. He came here in 1818 and bought one-half of Lot 97 which had earlier belonged to Dr. Powers, and was located on "West Diamond." (Now Main St.) He left Mansfield with his wife Reumah in 1822; and moved to Waterford, Erie County, Pennsylvania. Ten years later he was a member of the first Vestry of the Episcopal Church there. Ohio seems to have been too wild for him too.

Arrived in 1822

Dr. Allen G. Miller came in 1822, and his brother practiced with him. A. G. Miller continued here for 25 to 30 years and trained some of the later physicians. One Dr. Sweney was also in Mansfield before 1828, probably for a very short time.

Dr. William Bushnell came to Mansfield in 1828. He had studied medicine with a doctor in Trumbull County, and finished with a year at the Ohio Medical College at Cincinnati, after which he practiced medicine and taught school in New Orleans for a year. He was a prominent physician here for more than 50 years. He was a director of the Atlantic and Great Western railway; was interested in the old Richland County Historical Society; and served several terms in the Ohio House of Representatives. In 1878 he was appointed Ohio delegate to the International Congress on Prison Reform at Stockholm, Sweden.

In 1850 Mansfield had 31 physicians for a population of 1,733, or one doctor for each 55 potential patients. This was a definite over-supply, and in 1858 the number had dropped to 15.

Seven Served in Civil War

The Civil War brought more changes. At least seven Mansfield physicians served as Army surgeons; Drs. Cantwell, Keys, McMillen, Mitchell, Mowry, Patterson and Race.

Dr. J. Young Cantwell was born on Spring Mill Rd., near Mansfield in 1824; read medicine with Dr. J. M. Chandler in Mansfield until 1847, when he opened his own office here. He served as operating surgeon in more than 20 battles with the 82nd Ohio Volunteer Infantry, of which his brother James was colonel. In 1864 he was appointed inspector of hospitals for the Union Army and made Lieutenant Colonel. After the war he went to Alabama in the "Carpetbagger" era, but finally returned to Mansfield. Dr. David McMillen of Mansfield served as surgeon of a "Hospital Boat" on the Ohio and Tennessee Rivers. These boats carried the wounded back to established hospitals.

Among the doctors of the 1850 - 1900 period were Dr. George Mitchell and his son George Jr., and the Drs. James Craig, father and son (located where the De Yarmon Insurance Co. is now). Dr. A. J. Erwin came to Mansfield in 1870. He studied at the Royal London Ophthalmic College; commuted from here to teach at the Cleveland Medical College, and had a sizable box of cataracts he had removed.

Three "Fifty Year Men"

The Richland County Medical Society has three "Fifty Year Men" (Doctors in practice more than 50 years): Drs. J. L. Stevens and Ralph Wise of Mansfield and John A. Reed of Butler.

Dr. Wise, prominent eye, ear, nose, and throat specialist, graduated from Jefferson Medical College in Philadelphia in 1901. He practiced in his hometown of Millersburg until 1911, when he moved to Mansfield. He has been in practice for 57 years, 47 of them in Mansfield.

Dr. John L. Stevens, long Mansfield's leading surgeon, graduated at Starling Medical College in March of 1895 and located in Mansfield in April of that year. The first year he walked about the town to make his calls; the following year he bought a bicycle; and after two years in practice he bought a horse and became a full-fledged "horse and buggy doctor." He studied surgery in Europe and was one of the pioneers in the use of x-ray. He has been in active practice for 63 years, a remarkable record of achievement and endurance.

At the present time there are 88 physicians listed in the Mansfield directory, with men trained in nearly every possible specialty. Medicine has changed remarkably since young Dr. Powers first rode into the town with his saddle-bags bulging with pills and powders.

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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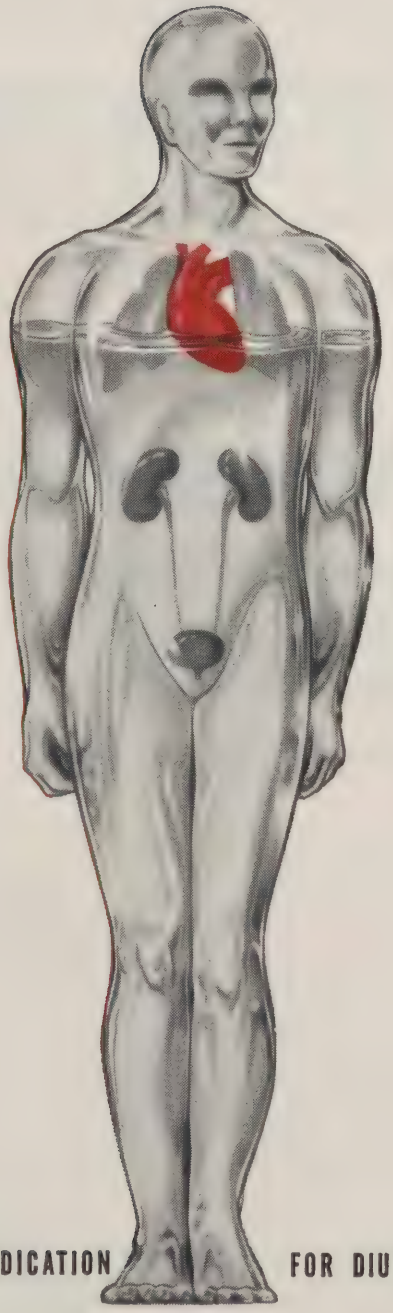
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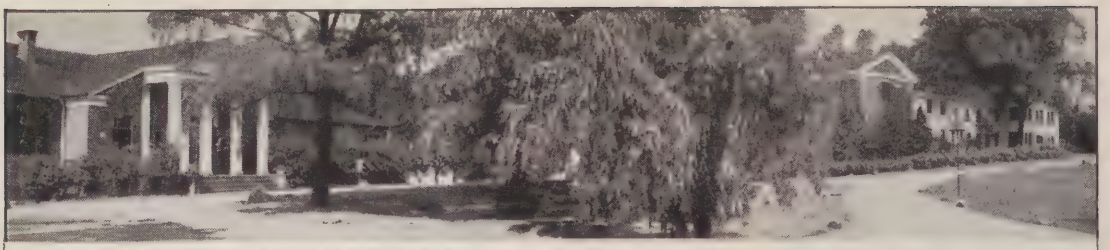
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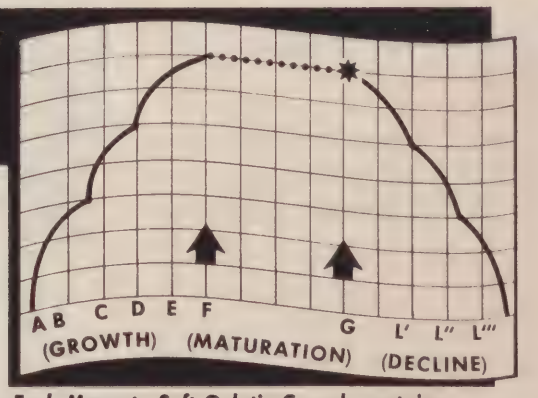
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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Vol. 54 November, 1958 No. 11

CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Tolbutamide: A Review of Its Mechanism and Its Role In Clinical Practice

GEORGE J. HAMWI, M.D., and RICHARD A. SERBIN, M.D.

SULFONAMIDE derivatives that have a hypoglycemic action have had extensive trial for the past several years both in this country and in Europe. In spite of intensive laboratory investigation the essential mechanism of action remains obscure. However, the clinical uses and limitations are becoming defined more adequately.

It is our purpose to present the salient facts known about these compounds and to describe the clinical results in our hands since one of these compounds, tolbutamide, became available to us in November, 1955.

Mode of Action

Janbon in 1942[1] was the first to notice the hypoglycemic effects of arylsulfonurea drugs during the course of his investigation of their antibiotic effects. In one of his studies on typhoid fever several of the subjects evidenced weakness, sweating and hunger which were shown to be due to a rather lowering of the blood sugar. Further investigation by Loubatieres[2] over the next several years established much of what is known about the action of these compounds.

It was found that the action of these drugs depended on the presence of islet cells, particularly the beta cell, of the pancreas. It has been repeatedly shown that this is true. There have been many opinions that the mechanism of action of these agents via the pancreas is to stimulate the remaining beta cells to increase their secretion of insulin. This question has not been completely resolved. Although it is generally agreed that the hypoglycemic effect is dependent on the presence of the pancreas, there is much evidence that the blood sugar lowering effect is not due to an increased secretion.

Increased carbohydrate utilization in the periphery has not been conclusively shown. On the contrary, studies using sugars other than glucose, such as D-xylose and L-arabinose, have shown that their peripheral utilization is not increased by the use of tolbutamide as it is with the use of insulin,

From: Department of Medicine, Division of Endocrinology and Metabolism, The Ohio State University, Columbus, Ohio.

The Authors

● **Dr. Hamwi, Columbus, is Professor of Medicine, and Chief, Division of Endocrinology and Metabolism, The Ohio State University.**

● **Dr. Serbin, Dayton, formerly with Division of Endocrinology and Metabolism, The Ohio State University and now in practice at Dayton, is on courtesy staffs of Miami Valley, St. Elizabeth and Good Samaritan Hospitals.**

in spite of a similar depression of blood glucose with the two agents[3]. This indicates that the action of the drug is not simply a matter of stimulating the production of the insulin by the pancreas.

Furthermore, in spite of the fact that both tolbutamide and insulin have blood sugar lowering effects, blood pyruvate levels are markedly different[4]. On the other hand, degranulation of the beta cells of the Islands of Langerhans of the animals after the administration of tolbutamide probably indicates that insulin has been released from the pancreas[5]. Until an increase in the concentration of insulin itself in the effluent blood stream of the pancreas can be demonstrated, direct proof of this very important problem cannot be given.

It has been postulated that the administration of the arylsulfonureas in some fashion interferes with the processes of insulin breakdown either through the mechanism of inhibiting "insulinase" or interfering with the other mechansims of insulin degradation[6]. The same body of evidence that has been marshalled against the insulin stimulating theory would apply equally here, as the net effect would be to increase the action of insulin. However, several investigators have shown that in animals which have been completely depancreatized for prolonged periods of time and which have been maintained on insulin, Orinase® has potentiated hypoglycemia[7]. While this piece of evidence does fit with the theory of inhibition of insulin destruction, it does not exclude other potential modes of action.

That these agents inhibit the formation of glucose from fructose and other sugars by the liver has been rather conclusively demonstrated in several laboratories[4]. This does not necessarily explain its clinical effects, although it is reasonable to assume that it has some importance. This action is not the only means of lowering the blood sugar, for these agents are still hypoglycemic in hepatectomized animals[8]. A mechanism of interference with the formation of glucose (gluconeogenesis) has not been established.

It has also been shown that tolbutamide interferes with one of the enzymes necessary for the conversion of glycogen to glucose (Glucose - 6 - Phosphatase) in vitro, but only in large doses[9]. Other agents which have been shown to have a similar effect on Glucose-6-Phosphatase have not been shown to have a similar blood sugar lowering effect.

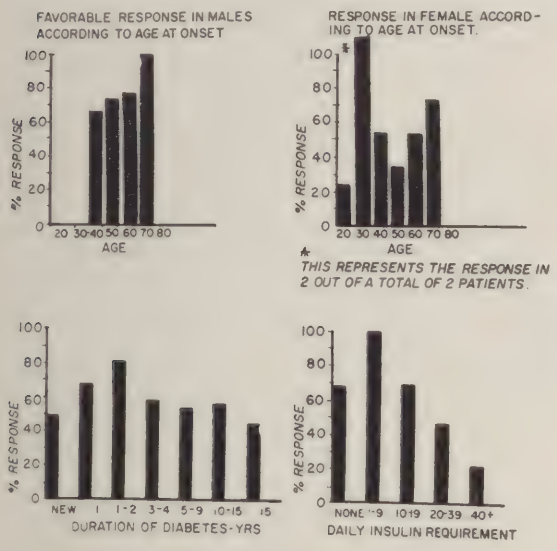
A substance elaborated in the alpha cells of the pancreas having a marked blood sugar raising effect has been identified. This substance has been called glucagon or the hyperglycemic factor and acts by speeding the breakdown of glycogen in the liver. The role of glucagon in diabetes is still obscure. Most people think that it has little importance in the pathogenesis of this disease. Nevertheless, there is no direct assay of this substance, and there is the possibility that this substance may be of significance in clinical diabetes.

It is distinctly possible that the oral hypoglycemic agents exert their effect by inhibiting the hyperglycemic factor. It has, however, been shown that the effect of exogenously administered glucagon is not affected by Orinase.[5] This still does not eliminate the possibility that endogenous production is inhibited. While not submittable to direct proof at present this must remain as a possible means of action. It also has the merit of explaining the need for the presence of functioning islet cell tissue. Morphologic changes of the alpha cells after the administration of Orinase have been inconstant in appearance and difficult to interpret.

The role played by the adrenal cortical hormones, somatotrophic hormone, and thyroid hormone in clinical diabetes is a subtle and at best a permissive one, except in the rather uncommon cases of steroid diabetes or acromegaly. Certainly in the vast majority of diabetics the role of these substances is minor in terms of pathogenesis. The possibility remains that the hypoglycemic substances exert a portion of their effect by inhibiting the action of one or several of these hormones. A mild and temporary antithyroid effect has been demonstrated after the use of tolbutamide. However, no instance of functional hypothyroidism or the development of goiter after the use of tolbutamide has been reported. The antithyroid effects, however, would not explain the prompt hypoglycemic effect.

Studies of the effect of these drugs in adrenalectomized or hypophysectomized animals have been performed. When these animals were completely pancreatectomized in addition to being hypophysectomized or adrenalectomized there was no blood sugar lowering effect, again demonstrating the primary importance of the pancreas. In dogs with an intact pancreas but without adrenals or pituitary glands the effect of the oral hypoglycemic agents was enhanced compared to the intact animals. However, the hypoglycemic effect is much more pronounced in the adrenalectomized as compared to the hypophysectomized animals. That there was this difference between the two groups is evidence that the mode of action is not by adrenal or pituitary inhibition or the two groups should have behaved in a similar fashion. Many other fragments of information are available but do not really clarify the picture significantly. Regardless of the mode of action of these drugs they do have undoubted blood sugar lowering effects in a num-

ber of diabetic patients. Our results in 138 cases as to age at onset, duration of diabetes, and insulin requirements are summarized below:



Clinical Evaluation

Even though the relatively small number of patients in our group does not lend itself to statistical analysis, certain trends are apparent. In our series an adequate response in the obese and well nourished group was approximately 60 per cent, but only about 30 per cent in the poorly nourished group responded.

In general, it may be said that the shorter the duration of diabetes, the older the age at onset, and the smaller the insulin requirement the better the chances of any one individual responding to the action of these drugs. Many clinical evaluations have corroborated these facts. However, in any single person these facts are of only limited predictive value, for even in the relatively younger age groups with high insulin requirements an occasional response is seen.

Discussion

The level of hypoglycemia resulting from a single dose of tolbutamide has been used as a screening test for the ability to respond to prolonged therapy, but experience generally has shown this to be an unreliable guide[10]. It is our feeling that a clinical trial of drug therapy is the only effective way of determining those patients who will have a response. We do not attempt a trial of therapy in juvenile diabetics, or in older persons whose diabetes is brittle with a tendency toward rapid onset of acidosis. But in the bulk of older, more stable diabetics, we feel that a trial of therapy is indicated. If no appreciable blood sugar lowering effect has occurred by three days the test is considered a treatment failure. Occasionally an equivocal response at this time warrants a more protracted trial, and we have seen a slow, prolonged, gradual diminution of blood sugar over a six week period in one patient with no appreciable change in diet as reflected by a stable weight.

Our usual dosage schedule has been a loading dose of one gram, three times daily, for one or two days, and then a maintenance dose of between .5 to 2 grams daily, usually given in divided doses. The maintenance dose will depend on the patient's response.

Toxicity with tolbutamide has been negligible. Reported incidence of minor side reactions has been about 2 per cent, most of these being transient dermatologic problems. No instance of serious, hematologic, hepatic, or renal disturbance has been reported in human beings. Crystalluria has not been a problem.

Fewer episodes of hypoglycemia occur than with insulin and this represents an advantage in therapy, particularly in the more elderly group with associated cardiovascular disease where the dangers of hypoglycemia are significant.

Since the urinary metabolite of tolbutamide is precipitated by acid, false positive tests for urinary protein are obtained if the reagent used to test for protein is an acid precipitant such as sulfosalicylic acid. It is recommended that positive tests for urinary protein be confirmed by heat or the recently developed Albutest®.

The ultimate role of these interesting drugs in the treatment of diabetes is yet to be established. At the moment of writing, these drugs have been found to be useful in a large group of diabetics and represents a significant advance as far as patient comfort and convenience are concerned. They are however, of no use whatsoever in the treatment of diabetic acidosis, and do not lend themselves to the control of a diabetic through such complications as surgery or severe infection. Nevertheless, patient enthusiasm for this drug has been very great indeed. Although only an impression, it is our feeling, based on spontaneous remarks of the patient, that there is a feeling of well being that is not present with the use of insulin. Whether this is due to the fact that they no longer have to go through the painful ritual of insulin administration, or to the fact that they are receiving a new, widely publicized drug, or whether this is a true drug effect is not known.

The possibility exists that these drugs may by nature of their effect on the beta cells of the pancreas, eventually cause their exhaustion. Clinical evidence to date, however, has not demonstrated this. Its long term use in a large number of pa-

tients without deterioration of diabetic status seems to controvert this notion. Also, patients who for unknown reasons, lose their response to Orinase after several months are generally satisfactorily controlled on their former dose of insulin.

Other oral hypoglycemic agents are being investigated, and may prove to have significant advantages over the presently available drugs. Such an agent is N^1-B-phenethylformadinyliminourea, also designated as DBI or PFU. Preliminary studies have shown that the drug is active in some patients who do not respond to tolbutamide. The clinical evaluation of this drug is now being undertaken at several centers and its advantages and disadvantages should shortly be known.

Summary

A brief history of the development of hypoglycemic agents has been given, along with a presentation of the salient features of mechanism. A resumé of the clinical evaluation is presented.

Conclusions

Although the mode of action of the arylsulfonurea drugs is still not established, the drug is a useful hypoglycemic agent in the majority of adult, stable diabetics and has little significant toxicity.

Acknowledgments: Grateful acknowledgment must be given to Dr. C. J. O'Donovan and The Upjohn Company for liberal supplies of tolbutamide and financial assistance. We are also grateful to the Comly Coleman Fund of the Ohio State University and the National Institutes of Health, Division of Arthritis and Metabolism, for their financial aid.

Addenum: Since this article was written our experience encompasses the treatment of 258 patients as of May 1, 1958. This added experience merely confirms the impressions and statements made in the article presented.

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Proper Choice of Tranquilizer

One thing I have noticed is a tendency to use whatever tranquilizer happens to be in vogue at the moment, rather than to prescribe on the basis of the patient's needs. Just as with other medications, these drugs have to be tailored to suit the individual.—Ralph Burbridge, M. D., Erie, Pa.: *Pennsylvania M. J.*, 61:999, August, 1958.

Medical and Surgical Management Of Bronchiectasis

It is important to realize that bronchiectasis is a serious disease and that once a lobe or segment has become fibrotic and contracted it is irrevocably lost. The treatment is both medical and surgical and is based on the extent of symptoms. Surgery is done if symptoms are of sufficient severity, if bronchiectatic changes are proved and adequately localized by bronchographic study, if cardio-respiratory reserve is adequate and if no other severe disease is present. Management is conservative when the disease is so slight that surgery seems unnecessary or so extensive that pulmonary resection cannot be considered. Conservative measures may be employed as a means of preparing patients for definitive surgery and in other instances as an ultimate form of treatment.

Some patients can be improved by active postural drainage, breathing exercises and the use of penicillin inhalations. Antibiotics have proved to be of considerable value in the therapeutic management. A period in the hospital under the active supervision of the physician and nurses will teach the patient the correct methods of postural drainage and of breathing.

The mortality of pulmonary resection in its various forms, even including bilateral cases and the complicated cases in all age groups, has decreased steadily in the past two decades until it has now reached levels that are gratifyingly lower than those for most comparable major surgical procedures. The hospital mortality is in the neighborhood of 1 to 2 per cent or less. It is of importance to note that the general condition of the patient and the extent of the disease are of far more significance than age.

Surgical management in children as in adults is an individual problem, but if possible, the operation should be at an age when reasonable cooperation may be expected, probably between the ages of 6 and 12.

It is well to remember that bronchiectasis is a dangerous disease and for the most part is associated with moderate to severe disability. There is usually a period of years of ill health. It is the opinion of most of those treating this disease that in the absence of contraindications of a formidable nature, resection therapy is the treatment of choice as it offers the best probability of permanent relief of symptoms. Segmental resection is used to its greatest advantage in the treatment of this disease as it increases the possibilities of bilateral excision.—Porter Mayo, M. D., Lexington, Ky.: *J. Kentucky State M. A.*, 56:865, September, 1958.

The Effects of Orinase® in Clinical Diabetes

CAROL E. CRAIG, M. D., JAMES L. CALVIN, M. D.,
and E. R. McNEAL, M. D.

SINCE the isolation of insulin in 1922, attempts have been made to find an effective, oral hypoglycemic drug. Many such agents have been tried only to be discarded because of their ineffectiveness or toxicity[6]. In 1942, Janbon was working with a sulfonamide preparation for typhoid fever. He accidently discovered that this agent had hypoglycemic properties. Since that time different sulfonylurea compounds have been studied. Orinase is one of these hypoglycemic drugs. It is the purpose of this paper to present our results with the clinical use of Orinase in 30 diabetic patients.

Of the 30 patients included in this study there were nine males and 21 females. The patients were studied from July, 1956, to September, 1957. Twenty-six were hospitalized and four were treated solely as outpatients. No regard was made as to the patient's age, weight, duration of diabetes, previous mode of treatment, severity of diabetes, or other pathologic states related or unrelated to diabetes. All we required was that the patients had diabetes mellitus.

No preliminary screening tests were done to help predict the final outcome of success or failure. Patients were placed on diabetic diets according to their caloric needs. Routine and periodic laboratory studies included a complete blood count, platelet count, urinalysis and liver function studies. Twenty-four hour quantitative urines were obtained until the urine was free of sugar, or until the trial was considered a failure. Blood sugars were obtained in the fasting and postprandial states.

TABLE 1.—*Relationship of Age at Onset of Diabetes and Number of Patients Controlled.*

Age in Years at Onset of Diabetes	Number of Patients in Each Age Group	Patients Controlled	
		Number	%
Below 20	1	0	0
20 — 29.9	1	0	0
30 — 39.9	2	0	0
40 — 49.9	9	5	55.5
50 — 59.9	6	3	50
60 — 69.9	6	6	100
70 — 79.9	5	5	100
Totals	30	19	63.3

TABLE 2.—*Relationship of Body Type to Number of Patients Controlled on Orinase.*

Body Type	Total No. of Patients	Patients Controlled	
		Number	%
Asthenic	6	3	50
Medium	14	9	64.3
Heavy	10	7	70

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The patients who were on long acting insulin were continued on that therapy until the day the Orinase was started. The insulin was then abruptly stopped. The usual starting dose of Orinase was 3 grams the first day followed by 2 grams the next day, with subsequent dosage adjusted to the blood sugar levels. Diabetic control was considered successful with a significant drop in the blood sugar levels, no glucosuria, control of diabetic symptoms, and no untoward reaction to the Orinase.

Table 1 shows the relationship of age at onset of diabetes and number of patients controlled. There were 19 successes, or we had an overall control rate of 63.3 per cent. We had one patient below 20 years of age who was a failure on Orinase. As the age of onset of diabetes increased the number of patients controlled increased, and in the 11 patients who were 60 years and older we had 100 per cent control. This finding is consistent with other studies[3, 4, 5, 7, 8] that is, it is the older diabetic who is most likely to be successfully controlled with Orinase.

Much has been written about the obese diabetic and control with the sulfonlyurea drugs[3, 5]. Table 2 shows the relationship of body type to number of patients controlled on Orinase. In many studies the obese diabetic had a distinct advantage. This was not as apparent in this series, as three of six or 50 per cent of the asthenic patients were con-

trolled. In the heavy group, seven of the 10 were controlled indicating that obesity, while it does play a role should not be a deciding factor as to whether or not to try Orinase.

We had a total of 11 failures. Of these four had the juvenile type of diabetes, three had allergic reactions to the drug, and one had chronic pancreatitis. Eight of the 11 failures had previous ketosis. Ketosis occurred in all age groups from below 20 to 60 years. We had no instance of success in patients with a previous history of severe ketosis and acidosis. This would suggest that previous ketosis is a contraindication to successful control of diabetes with Orinase.

Table 3 shows the relationship between previous mode of therapy and subsequent successful control on Orinase. The first column shows the previous dose of insulin, the middle column the number of patients in the group, and the last column the number of patients controlled. The patient with over 80 units of insulin was not controlled. The four patients with 60 to 80 units also were not controlled. Of the five patients who

TABLE 3.—*Relationship Between Previous Mode of Therapy and Subsequent Successful Control on Orinase.*

Previous Insulin Dose in Units	Number of Patients	Patients Controlled	
		Number	%
Over 80	1	0	0
60 — 79.9	4	0	0
40 — 59.9	5	2	40
20 — 39.9	2	2	100
Below 20	6	6	100
Totals	**18**	**10**	**55.5**
No Previous Insulin Therapy	12	9	75

were taking 40 to 60 units two were controlled and of those taking less than 40 units, all were controlled.

There were 12 patients who had had no previous insulin therapy. Of these nine were controlled. Of the patients with previous insulin therapy, 55.5 per cent were controlled while 75 per cent of the patients without previous insulin therapy were controlled. As in other series[3, 4, 5, 7, 8], Orinase was most successful in patients who had had no previous insulin therapy or in those in whom the previous insulin dosage had been low.

We did have three drug reactions. The first of these was that of fever, nausea, vomiting and lethargy which cleared after the drug was stopped. Three months later this patient was again given Orinase and although there was no fever—nausea, lethargy and generalized body aches developed. The second was that of urticaria in a patient who had previously reacted in a similar manner to Gantrisin®. This also subsided when the Orinase

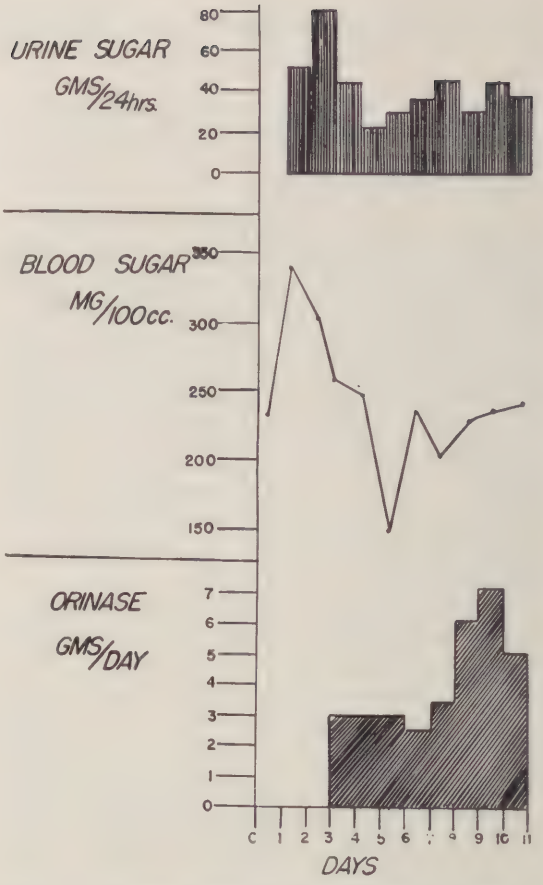


FIG. 1. Clinical course of a patient who was a failure on Orinase.

was discontinued. The third was that of a papular eruption, primarily of the face, that developed in the ninth month of treatment. This also cleared when the Orinase was stopped.

Some examples of the successes and failures follow. Figure 1 is a chart showing the clinical course of one of the failures. This patient was a 41 year old white male not on previous insulin. Before Orinase therapy he had blood sugars between 235 and 340 mg. per 100 cc. and was spilling up to 80 grams of glucose per day in the urine. Orinase was given in three gram doses for three days and on one day the blood sugars dropped to as low as 150 mg. per 100 cc. However, following this, and despite high doses of Orinase up to 7 grams a day, the blood sugars rose and remained above 230 mg. The glucosuria continued. This man was a failure on Orinase and was subsequently controlled on insulin.

Figure 2 is a chart from the record of a 66 year old white male. He had not taken insulin and had never been on a planned diet. He was treated as an outpatient. His initial blood sugars were about 430 mg. per 100 cc. He was placed on a diabetic

diet for about three weeks. His blood sugars dropped to about 225 mg. He was started on 3 grams of Orinase with gradual reduction of the dosage. His blood sugars were reduced to a low of between 108 and 120 mg. It was decided to try him without Orinase for four days to see what the blood sugars would do on diet alone. This was done and his blood sugars again rose to around 225 mg. Orinase was started again with a return of blood sugars to below 140 mg. indicating successful control on Orinase.

Figure 3 shows a long term successful control on Orinase. This patient is a 63 year old white male who had previously been treated with insulin without good control. He had received from 40 to 50 units of insulin per day. Blood sugars ranged in the high 200's. Orinase was started on the patient in the hospital. He was continued on 1½ grams of Orinase per day, later dropped to 1 gram per day and, following his course over a nine month period, all of his blood sugars are in the range of 125 mg. per 100 cc. with no glucosuria. He had excellent control on Orinase. However, after nine months of treatment, Orinase was discontinued because of a skin reaction. Again he is only fairly well controlled on NPH insulin.

Summary

In summary, the clinical response of 30 diabetic patients to Orinase was tested. Nineteen or 63.3 per cent were controlled on Orinase. Patients who were most easily controlled were elderly diabetics, those who had had no previous insulin therapy, or those who had received less than 40 units of insulin per day. Patients who did not respond were the juvenile diabetics or those who had a previous history of ketosis. The heavy type individual had a slight advantage; however, 50 per cent of the asthenic type and 64.3 per cent of the normal weight individuals did respond. Three allergic reactions did occur.

Time will determine what the future role of Orinase will be in the treatment of diabetes mellitus. It should be emphasized that Orinase is not a substitute for insulin therapy. Many clinicians feel that all diabetics should be taught how to use insulin, as it is a well known fact that Orinase is not effective in times of infection, trauma, surgery or any stress situation[1, 2, 3]. However, on the basis of the experience in this series of patients, it would appear that Orinase is a convenient and successful method of treatment for the older, mild, adult-type diabetic patient.

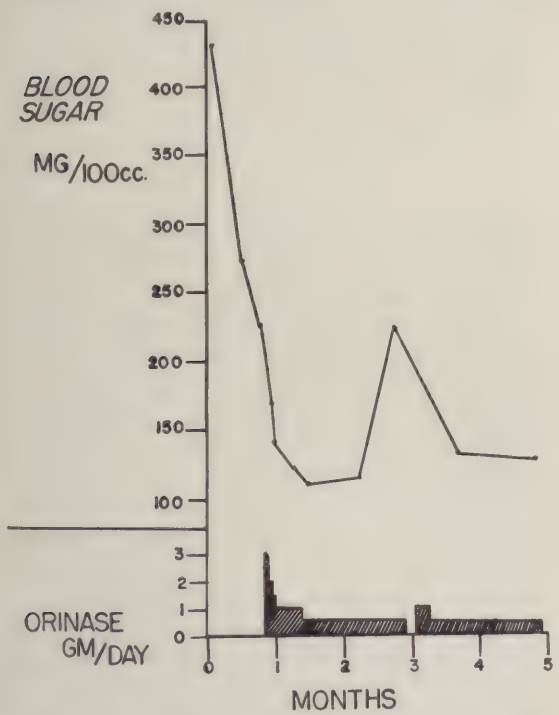


FIG. 2. Clinical course of a patient not previously treated with insulin showing successful control on Orinase.

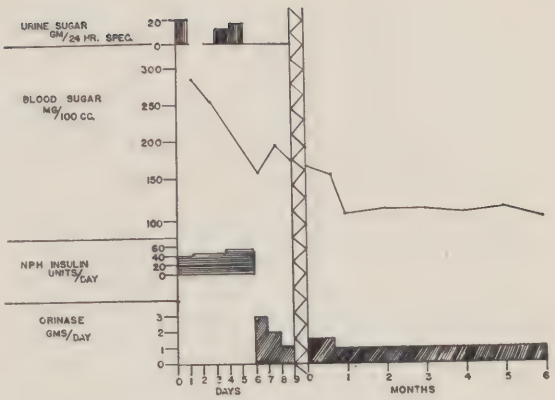


FIG. 3. Clinical course of a patient previously treated with insulin and subsequently controlled on Orinase.

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Objectives of Effective Diabetic Management

JOSEPH I. GOODMAN, M. D.

IT is now 37 years since insulin was introduced as a specific drug for diabetes mellitus. This epochal contribution has resulted in a longer life for many diabetics, but also has caused unforeseen difficulties and misunderstandings for the medical profession. A mist of confusion about insulin therapy has slowly arisen and so far has shown little evidence of clearing. A practitioner, caught in the morass of disagreement, becomes increasingly befuddled.

Once the diagnosis has been established the physician must provide himself with a thorough history and physical examination in order to treat not only the diabetes but any associated disorder. First and most important is a search for any evidence of ocular involvement. Does the patient complain of pain or paresthesia suggestive of diabetic neuropathy? Are there indications of vascular impairment or ulceration of the lower extremities? Albuminuria may denote intercapillary glomerulosclerosis. The presence or absence of these stigmata will help us to determine whether the diabetes is of recent origin or long standing.

The therapy of diabetes is not simple, but too often medical writings on this subject make it appear more complex than necessary in the light of present-day knowledge. Details of therapy are too frequently maintained at the research level instead of being reduced to those essentials necessary for clinical application.

Objectives of Diabetic Control

What constitutes control of diabetes? Of course the ideal objective would be restoration of the individual to normal. Since diabetes is incurable few, if any, patients attain this goal. In actual practice one seeks to provide a regimen which brings about optimal regulation and minimal interference with normal living habits. The objectives are: 1. Relief of symptoms and maintenance of physical and mental well-being; 2. achievement and maintenance of normal weight; 3. prevention, postponement or minimization of complications. The necessity of avoiding keto-acidosis and insulin reactions is acknowledged by all and, since they are largely preventable, their occurrence is for the most part inexcusable. The relief of symptoms and maintenance of normal weight are objectives which can be easily realized in cooperative patients by the appropriate use of diet, Orinase® and insulin. In most cases the relief of symptoms is accomplished so easily as to be hazardous. One should aim to help a patient remain active and useful in his or her community endeavors.

The Author

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The first step in the treatment of diabetes is not any particular diet or kind of insulin but the emphasis on *control.* Too many people abhor the word discipline but it is this which makes for the successful treatment of diabetes and represents the foundation of that morale which is observed in great soldiers. There is always a cause of failure; perhaps the patient, family or physician, self-indulgence or neglect.

Juvenile Diabetes and Prevention Of Vascular Lesions

The diabetic child need not present an unusual problem. Regardless of the school of therapy, there is general agreement that the standards of satisfactory treatment should be the absence of symptoms, the attainment of normal growth, physical health and wholesome emotional development. Moreover, sound clinical control of the diabetic child is directed toward preventing or delaying the vascular complications of long standing diabetes. Successful management depends upon the joint efforts of physician, parents, and child.

The modern treatment of the diabetic patient must include as its primary goal the prevention of vascular complications. Although achievement of this success is not immediately at hand, it appears that progress lies in the direction of optimal control of the metabolic abnormality. Frederick M. Allen maintains that the complications of a diabetic are uniformly preventable and, if present, may generally be arrested by vigorous control.

What is the dividing line between satisfactory metabolic balance and the early defections which if not controlled would lead to complications? The answer to this question is important. With an increasing number of children and adolescents, there will of course be an increasing number of young people with diabetes. One hopes to protect them not only from diabetic coma and other acute complications, but also from the disasters of complications of the nervous and vascular systems some 15, 20, or 25 years hence.

Management of the Ambulatory Diabetic Patient

Until recently the hospital was generally believed to be the best place for the initial treatment and instruction of the patient with even uncomplicated diabetes. In the past, hospitalization of patients with newly discovered diabetes was deemed essential primarily for two reasons: dietetic training, which most physicians are not prepared to give in necessary detail, and instruction in the use of insulin. Today, a number of circumstances have combined to make it a less desirable place than the doctor's office for the purpose.

The shortage and expense of hospital beds constitute a deterrent to hospitalization. For persons without hospitalization insurance the cost of board and room alone has risen to unprecedented heights. On the other hand, the very success of the insurance program has resulted in the filling of hospital beds almost to capacity, so that patients often must wait to be accommodated. When they are finally admitted, the chronic shortage of nurses, and recently of interns, is a discouraging obstacle to proper care and training. Even if a patient is willing to stay in the hospital, his regimen must be altered in the direction of increased calories or decreased insulin dosage or both when he returns to his usual activities. Finally, in most hospitals the principal meals of the day are telescoped into the brief period between 8:00 and 8:30 a.m. and 4:30 or 5:00 p.m., so that the timing of insulin action in relation to food intake is quite different from that which obtains on the patient's customary schedule.

While there will always be some patients who should be hospitalized, the majority can be managed with complete satisfaction in a well equipped office or outpatient department. Such management, if it is to be successful, must include the instruction of the patient as one of its major aims. This requires of the physician the willingness to teach and the time and patience to do it. Actually both dietetic training and instruction in the use of insulin can be given readily by the doctor in his own office or in the clinic setting. With the increasing shortage of hospital beds and increased expense to a patient more and more people will find it necessary to seek outpatient or office care. If the patient can continue to work while his diabetes is being controlled the cost is reduced, and, more important, he is assured that his condition can be controlled by his own physician.

Education of the Diabetic Patient

Diabetes is a lifelong condition which demands more participation by the patient in his own care than any other disorder. All diabetic patients should be taught as much about their condition as their capabilities for learning will permit. A physician who accepts the diabetic as a patient assumes the trust and responsibility of giving that patient the advantages of all the factual information amassed over the years. Furthermore, he should assume from the outset that the patient will be dependent upon him for such advice as will enable him to enjoy maximum health over a period of years.

While the value of patient education has never been questioned, the degree of success achieved currently has been. Those dealing extensively with diabetic patients find that both new and old patients are equally in need of education and constant re-education. Both groups have their share of misconceptions about the disease. It is therefore fallacious to assume that a diabetic, however long his course, has been properly indoctrinated. Moreover, the elderly diabetic who is extremely forgetful constitutes the largest group to be taught and a great challenge. Children are no exception. In the case of younger children, it is of vital importance that the parents be thoroughly familiar with the basic facts regarding the nature, treatment, and possible complications of diabetes. Every opportunity must be taken, either individually or in classes, to instruct patients and their families.

Education does not consist simply in presenting the basic facts of diabetes to patients. Rather, it should be directed to a real understanding of the disorder and a proper attitude toward its management. Does the patient understand the causes of acidosis? Does he know what to do if he has taken insulin and cannot eat, or whether to take insulin if illness prevents his eating? Has he been adequately indoctrinated in the care of the feet? Adequate instruction by physicians, nurses, and dietitians is most important. This can be accomplished efficaciously for large groups in outpatient departments. Finally, the patient should be given definite written instructions dealing with diet, foot care, insulin instruction, and the haz-

ards of self-surgery and self-medication should be clearly underlined. The potential seriousness of diabetic complications should be presented in their proper perspective.

At the initial visit, the patient is requested to continue his previous food practices and record them, to take insulin, if any, as before. Every new patient should be given dietary and insulin instructions in the first week of treatment. Encouragement and optimism is a primary part of such treatment. At the second visit the patient brings his food diary, insulin equipment and a 24-hour specimen of urine for quantitative analysis. Regular visits to the physician are important in maintaining satisfactory control.

Moral Support

On first learning of his diagnosis the diabetic patient is besieged with many fears. He worries about the effect of the illness on his future activities and employment. He has already heard of insulin and usually dreads the thought of needles. He has visions of severely restricted diets and fears the loss of eating pleasures. To the patient the immediate picture is one of gloom and a lifetime of drudgery. With some patients, the terms "diabetic gangrene," "insulin shock," and "death" strike a familiar note. Later the diabetic is struggling daily with an unnatural regimen of prescribed meals and hypodermic injections, and the tendency to grow careless and take liberties with the diet increases as time goes on. Parental attitudes are extremely important in the management of childhood diabetes. They can vary from the overly permissive to the overly restrictive. Overanxious parents may create an overanxious child, and the result may be psychologic invalidism or—quite the reverse—defiant revolution. Indulgent parents may be exploited by the child, whereas perfectionist parents may transform their child into a "diabetic robot."

In the past we have failed to capture the interest and enthusiasm of the diabetic patient for continual and lifelong self-care. There has been overemphasis on giving the patients purely medical facts, and not enough attention to promoting proper psychologic attitudes toward their condition. Psychologically, any shock caused by emphasizing the permanency of diabetes and diabetic adherence can be cushioned by citing reassuring statistics on the longevity of diabetics. Diabetes has been changed from a metabolic *disease,* incapacitating and progressing slowly or more rapidly to an inevitable end, to a metabolic *defect* and this defect is controllable by suitable, though different, diets and the skillful application of insulin, thus enabling the patient to live long, happy, and useful lives. The physician can use these weapons to strengthen his patient's morale, and to make his patient see that science has discovered a way to train him to win the game.

Generally speaking, the physician who is aware of the emotional needs of the diabetic child and the parental adjustments required should be capable of dealing with most of the problems. It is the physician's responsibility to plan a course which will bring about optimal growth and development and as normal a life as possible. With the full cooperation of parent and child this can in most instances be achieved.

The family physician therefore becomes an important buffer in allaying the patient's unhappiness and fears. He must reassure the patient that dietary restrictions will be neither unreasonable nor severe. He must explain to the patient that the daily administration of insulin will become a routine to him, no worse than his daily ablutions. The fear of insulin shock and gangrene can be allayed by explaining that they occur only in the poorly regulated patient and that these dangers will be obviated by the regime upon which he is to embark. These explanations and reassurances must be repeated on subsequent visits, because the diabetic is usually so stunned on his first visit that he retains very little of what is told him.

In summary, a physician should seek to further the patient's welfare by sympathetic understanding of his psychologic welfare, as well as the immediate complaint. It is his duty to give the patient an objective—a definite task to perform that will stimulate hope and peace of mind. One such objective may be to inspire the diabetic to strict adherence to his daily routine in order thereby to compete with the nondiabetic for longevity. A patient who consults his doctor regularly, improves his prognosis. It is just as important for him to see his physician regularly as it is for some people to go to church every Sunday, and, in part, for somewhat analogous reasons.

Role of Diet in Diabetes Mellitus

The ideal caloric allowance is one that over an extended period will maintain body weight or rate of growth at the level most conducive to well-being. The patient's weight is a vital measuring stick, because it is only in relation to his immediate weight status that we can intelligently select a diet. The attainment and maintenance of normal body weight are not difficult in cooperative patients.

Most obese diabetics do not need insulin for the control of the diabetes provided proper attention is paid solely to their obesity. A return to

normal weight often parallels the complete disappearance of glycosuria and hyperglycemia, or at least a marked amelioration of the diabetic state. The underweight diabetic must be given a diet which will permit him to gain even if it means 3000 to 4000 calories per day; glycosuria can be controlled with insulin. The major goals in the dietetic management of the juvenile diabetic are to: (1) Meet the nutritional needs for growth and development; (2) keep the food intake relatively constant in amount from day to day; (3) adjust the diet as far as possible to the family meal patterns and personality of the patient, recognizing that practicality and flexibility assures a greater degree of cooperation.

In general, *when a diet designed to correct abnormal body weight or maintain normal body weight fails to render the urine sugar free, the use of Orinase or insulin is indicated.*

Hyperglycemia and Glycosuria

Any plea for good diabetic control should state what is meant by the term, how often it is attained in practice, and what is the method of producing it. The most common method in use for evaluating the dosage of insulin is examination of the morning urine specimen for sugar and an occasional fasting blood sugar. As John points out[1] one can never procure enough data from the blood sugar level in any one 24-hour period to provide a clear picture of the patient's course and his changing needs for insulin. This author presents some interesting case histories to illustrate how misleading an occasional, random blood sugar determination can be, as well as an isolated fasting blood sugar. Moreover, the blood sugar data represents the condition only at the very moment the blood is drawn, a figure which may have been vastly different a few minutes earlier or later, or even at the same hour on another day. Perhaps the most important thing one can say of the blood sugar value is that it must not be overinterpreted. I resort to blood sugar determinations only occasionally to check on a possible hypoglycemia and for glucose tolerance tests.

Data on urine sugar, when expressed as 1-4 plus, are far from quantitative, since 4 plus sugar may represent concentrations varying from 1.5 all the way to 6-10 per cent[2]. Spot urine tests are valueless as in the case of the blood sugar. As a matter of fact, they usually are misleading. The second thing to consider is the fact that a concentrated urine specimen of small volume may show considerable sugar qualitatively; on the other hand, a dilute large volume specimen may show only a faint trace or a trace qualitative reaction when, in fact, the actual amount of sugar in both specimens proves to be identical. The author gauges the efficacy of the treatment by means of quantitative determinations of the urine sugar carried out for the entire 24 hours and tested by the method of Somogyi[3].

The quantitative glucose content, as determined in total 24-hour urine specimens, provides an objective criterion which is useful in evaluation of the degree of control of the individual. Estimation of the 24-hour, quantitative urine sugar is of considerable value, in that it indicates the exact amount of glucose excretion which, in turn, tells us what proportion of his carbohydrate intake is utilized. A maximum excretion of 10 grams of glucose is acceptable to most authors. If more than 10 grams of urine glucose per 24 hours is excreted a change in the regimen is indicated. Moreover, this seems to be a practical standard whereby the systems of management practiced in different centers can be compared.

The use of a graphic chart is extremely valuable in the management of diabetic patients. As is the case with a temperature graph depicting typhoid fever, pneumonia, etc., one can comprehend the picture at a glance. On this chart one records the quantitative sugar data, insulin dosage, weight, and dietary data at each visit. On subsequent visits one can quickly size up the situation and correlate the immediate findings with previous data frequently going back many years. I have maintained such graphic records for over 12 years and find them well worth the extra effort, for the control of diabetes is a systematic, rational procedure.

What Is "Mild" Diabetes?

The type of diabetes most frequently mistreated is the common variety seen in the middle-aged and older obese groups of patients. Fully one half of all of the two million or so diabetics in this country fall into this category. In them the diabetic state either escapes detection or is labelled "mild" simply because symptoms are absent, or because insulin requirements are low. Most of them are mismanaged, due to indifference either on the part of the patient, his doctor or both. Little attention is paid to the diabetes until complications appear and then it is too late.

A woman described by McLaughlin and Bradley[4] illustrates the point vividly. Only a few years after learning of her condition the "mild" diabetes became associated with neuropathy, retinopathy, occlusion of an axillary artery, myocardial damage by electrocardiography and, finally, cerebral artery thrombosis. It is so mild, that like minimal tuberculosis or malignancy, more is to be gained by meticulous care than after it has pro-

gressed in severity irreversibly. In spite of increasing indications that haphazard treatment is harmful there are still many who accept it complacently. This leads to the paradox that only a small fraction of patients are well regulated, even though 80 to 90 per cent could be.

Diabetes is diagnosed in the majority of patients by casually discovered glycosuria. Many physicians still have difficulty in accepting the concept that this asymptomatic stage of diabetes is an early phase of a disorder, even though they have been conditioned to do so in diseases such as leukemia, cancer, and others. Consequently the majority of patients too frequently receive a half-hearted diagnosis couched in vague terms such as "sugar in the urine or blood"; often even the use of the term diabetes is omitted. Little wonder that these patients entertain doubts regarding the reality or significance of their condition. After the laboratory findings have been normalized by therapy, some patients may be erroneously told that the diabetes has been cured or never existed. The patient is only too willing to grasp at this straw and may disappear from medical purview. Subsequently, the disease or its complications is likely to return them to the fold much the worse for the experience.

Contrasted with the clinical picture before the discovery of insulin, the institution of insulin *seems* to solve most of the immediate problems of the mild diabetic. First, insulin keeps most diabetic patients alive and feeling well even in the presence of persistent glycosuria and hyperglycemia. Symptoms, if present, are usually diminished or eliminated, weight is maintained, acidosis is easily avoided, as a rule. Second, an ad lib diet, with enough insulin to control symptoms, is an easier method of treatment than one which demands a rigid chemical balance. An improperly briefed patient is more prone to misinterpret the allowable freedom of food exchanges as a license to make unphysiologic shifts in food. Little knowledge or determination are required to take insulin, eat according to one's whims and ignore blood or urine sugar tests.

After several years of poor regulation, certain mental and personality changes are observed in diabetics of all ages which tend to make them forgetful, stubborn and opinionated. Two major difficulties then ensue: (1) the discrepancy between the problem of self-care and the capability of the patients increases and, (2) due to poor judgment, the division of authority between doctor and patient becomes increasingly hazy in the latter's mind.

Too often the patient's indifference is caused by his medical advisor's attitude. As previously mentioned, the diagnosis and prognosis of diabetes are not explained to a large proportion of patients convincingly enough at the onset of the disease. The physician who condones freedom of action usually meets with the patient's favor for prescribing an easy, convenient method which is just what he wants.

The type of diabetes under discussion is the easiest to balance pèrfectly and, in the author's opinion, the most important kind to treat this way. These cases respond beautifully to a little effort, knowledge, and a conviction that something is to be gained by doing so. Perfect control of these patients can be achieved by intelligent planning of the diets, loss of excess weight, the daily use of Orinase in some cases and of small doses of insulin in others, and frequent quantitative urine tests to guide the course.

First, it is necessary to expose the fallacy that a chronically poorly regulated diabetes necessarily reflects itself in subjective symptoms or in a fasting (rather than two-hour postprandial) blood or urine test. Food intake must be constant from day to day until it is known to be constant and uniform. There must be proper appreciation of the timing qualities of the various insulin preparations and selection of the one most suitable for the individual behavior as seen in the fractional urine results. Discipline and consistency of habit are the chief reasons for successful results. For all we now know perfect regulation prevents many complications and may postpone vascular lesions indefinitely. Actually both physician and patient profit by the knowledge that insulin reactions are avoidable by scrupulous attention to the details of diet and insulin administration.

It is my firm belief that another generation of diabetics managed according to these principles will tell a different story about the inevitability of diabetic complications. The only reason that this fact is not demonstrable now is due to the failure of regulation in too many patients and lack of encouragement to do so on the part of many doctors. If this concept is valid, here is an opportunity to practice preventive medicine in its purest form. We have the means to keep diabetics alive; now we must learn how to keep them well.

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Some Interesting Observations in Diabetes Mellitus

HENRY J. JOHN, M. D.

I AM presenting some observations on diabetes in 10 cases, each of which presents some interesting observations which happen in everyday practice.

Case 1. A boy, 9 years old when I first saw him on October 2, 1936, at which time his blood sugar at 3 p.m. was 42 mg. per 100 ml. at which time he had been on diet alone for a while. Only two days later, the blood sugar, at 3 p.m. when he was on the same diet was 341 mg. per 100 ml. Thus he was put on insulin, 10-10-10 a day. By December 29 at which time the insulin was reduced to 7-0-7 units a day, his blood sugars, taken three times daily, before meals, were: 57-36-87 mg. per 100 ml. and thus the insulin was reduced to 8-0-0 units, taken after breakfast.

Even on this small dosage, on February 22, 1937, his blood sugars on 8-0-0 were: 46-37-53. Thus the dosage was reduced to 6-0-0 and taken after breakfast. At that time he was on a diet of 180 Gm. carbohydrate, 80 Gm. protein, 128 Gm. fat, a total of 2100 calories. His weight rose from the original 53 pounds to 62 pounds. He became careless then with his diet and the insulin had to be raised to 60-0-0 units of protamine zinc insulin.

In 1948 he was in diabetic coma on February 5 so that when he was brought out of coma he had to take 80-0-0 units of protamine zinc insulin a day when his blood sugars were: 95-65-143. On November 23, 1954, at which time he was 27 years old, he showed retinal hemorrhages and was taking 35-0-0 protamine zinc insulin a day and the blood sugars were: 47-125-184 mg. per 100 ml. Then I lost track of him and he was married in the meantime. He died on September 13, 1955 at Mt. Sinai Hospital where he was taken in severe coma and was taken care of by the hospital staff.

At autopsy the section showed the following:

1. Diabetes mellitus: a. Hypogenesis of the islets of Langerhans.
2. Acute pancreatitis.
3. Hypertophy of the heart (weight 450 grams).
4. Passive hyperemia of viscera.
5. Pulmonary edema.
6. Hemorrhages of the stomach.
7. Arteriosclerosis: a. Coronary (marked), b. Aortic (slight).
8. Arteriosclerosis of kidneys.
9. Hemosiderosis of spleen (moderate).
10. Blood sugar 920 mg. per 100 ml.

The Author

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Here we have a boy who developed diabetes at 9 years of age and which, for a long time, was mild. As he reached maturity, he became more and more careless and diabetes became more severe. At 27 years of age he died in diabetic coma and the report of the section shows the extensive findings.

Infection the Cause of Diabetes

Case 2. A boy, 6½ years of age in 1949. In that same year he developed virus pneumonia and diabetes followed immediately after that. I saw him for less than two years, during which time he had to take as much as 16 units of protamine zinc insulin and 23 units of insulin a day and still was not under good control. I lost track of him after June 1950. This instance shows how infection can bring on diabetes quickly.

Case 3. A boy, 8 years old. On June 30, 1951, he developed mumps and I saw him on August 16, 1951, at which time he had a frank case of diabetes mellitus in spite of the fact that his blood sugars on that day showed: 52-308-340 at which time he was taking no insulin. On insulin and diet he has been under a fair control since then and at present, 1957, he is taking 26 units of NPH insulin and 6 units of insulin in the morning.

Mumps frequently is the cause of diabetes in children and one should be on the lookout for it in all cases of mumps.

Hypoglycemia Without Symptoms

Case 4. A girl, 18 years of age. When I first saw her on November 25, 1952, she was taking 20 units of protamine zinc insulin and 40 units of insulin in the morning. At that time she had had diabetes over two years. On that same day and the above dosage of insulins her blood sugars were: 116-47-25 mg. per 100 ml. The interesting thing was that at the time of the low noon and evening blood sugars she had no feeling, nor symptoms, of hypoglycemia feeling perfectly

normal. I reduced her insulin and she got along well, not experiencing any insulin reactions.

The patient married in January, 1954 (at age 20) and became pregnant that same year. On November 19, 1954, at which time she was taking 68 units of NPH insulin in the morning, her blood sugars were: 63-31-40 mg. per 100 ml. and again there was no consciousness of hypoglycemia. The insulin dosage was reduced to 60 units of NPH insulin on which she was well controlled. On January 27, 1955, a cesarean section was done, the baby weighing eight pounds. Shortly after that the insulin dosage was gradually reduced to 44 units of NPH insulin with a good control to date.

The interesting thing here is the fact that with such a hypoglycemia the patient was not conscious of it, a fact which I have encountered many a time.

Drop of Blood Sugar Without Insulin

Case 5. This is an interesting case showing a marked drop of blood sugar without insulin. A woman 36 years of age in 1954. She has had diabetes since 1948 and was on 20 units protamine zinc insulin a day on which she was well controlled. She had retinal hemorrhages. I placed her on 20 units NPH insulin a day for four months when all insulin was discontinued. On September 30, 1954, at which time she had been off of insulin for four months, she showed the following figures of the blood sugar: 306-243-72 mg. per 100 ml. and that without any insulin. I then placed her on 10 units NPH insulin on which she is in good control.

The interesting thing here is the fall of blood sugar on September 30, 1954, without any insulin, from 306 to 72 mg. per 100 ml., meals between.

Diabetes in Twins

Case 6. A physician, 65 years old in 1950 when I first saw him. At that time he had had diabetes for just a few months. He was carefully dieting and by this alone had controlled his diabetes well. Two of his sisters were diabetic and a twin brother had developed diabetes at 15 years of age. The physician developed diabetes at 65 years of age.

Many years ago I have shown the incidence of diabetes in twins which can occur either spontaneously or many years apart, a fact to bear in mind in all twins where one is a diabetic. Here we have an instance where one of the twins developed diabetes at 15 and the other at 65 years of age.

Delayed Cases of Diabetes

Case 7. This woman, 46 years of age I saw first in 1938 at which time she had a normal blood sugar two and one-half hours after a heavy carbohydrate meal. This examination was done because in 1921, during her pregnancy, she showed glycosuria and hyperglycemia all during pregnancy. On a restricted diet alone she managed well. However, in 1942, she developed a frank case of diabetes. In 1949 when I first saw her, her blood sugars, three times daily, before meals, were: 109-103-80, the last blood sugar being taken two and one-half hours after a heavy carbohydrate meal. However, in 1950, the blood sugars were: 167-161-107 on diet alone. Since then she remained a mild diabetic. Her mother and her daughter have diabetes. The daughter who was obese, developed diabetes at the age of 16, in 1938.

Case 8. Woman, 49 years of age in 1936. Her history was that seven years previously she showed glycosuria and that she had been on a reduced diet ever since. When I first saw her on Oct. 27, 1938, all her blood sugars were normal and there was no glycosuria. On Nov. 3, 1938, I did a glucose tolerance test which too was normal, in fact on the low side. However, in 1950 when I saw her next, she showed hyperglycemia throughout the the day. Then I did not see her until Oct. 29, 1952, at which time she was taking 40 units NPH insulin a day on which she was well controlled. This dosage, over a period of three years was reduced to 30 units which was quite adequate.

Here we have a woman who in 1929 showed glycosuria and hyperglycemia and who, at that time was on insulin for three months, had straightened out completely and for seven years showed no hyperglycemia. Even when a glucose tolerance test was done this was normal, but 14 years later she developed diabetes again and has it to this day, and is well controlled on 30 units NPH insulin. This confirms the old saying: once a diabetic, always a diabetic even though there may be an interval of a non-diabetic condition between, lasting for several years.

A Mistaken Diagnosis

Case 9. A young girl 17 years of age in 1949. I saw her first when she was sent to hospital because of abdominal tenderness which was interpreted as acute appendicitis. She was sent in for an operation. It was obvious to me that the child was in severe acidosis. Her blood sugar was 450 mg. per 100 ml., CO_2 was 26.7. On heavy dosage of insulin up to 110 units the first day she was soon under control requiring after that only 30 units PZI insulin a day and 20 to 25 units of insulin.

There was no appendicitis and later she was well controlled on 18 units and still later on 12

units of protamine zinc insulin a day which was later reduced to 10 units. All the blood sugars during that time three times a day, before meals, were normal; in other words a perfect control. In fact on July 25, 1950, all insulin was discontinued and all subsequent blood sugars, three times daily, before meals, on that day, without insulin were: 116-227-563. Then evening insulin was resumed and she did quite well on 20-0-20 NPH insulin a day, she went then to college, graduated and married in 1954 and is under good control on 34 units NPH and 16 units insulin taken in the morning.

The point I am stressing is the gastrointestinal upset on Sept. 11, 1950, which completely upset a mild case of diabetes. It also shows the importance of checking the blood sugar three times a day, before meals, for on that day the fasting blood sugar was normal, namely 116 mg. per 100 ml.

Ruling Out Diabetes Does Not Mean That Patient May Not Develop It Later

Case 10. A woman, 52 years old in 1951. At that time she told me that she had had glycosuria for five years. Upon a close checkup on October 29, 1951, diabetes was ruled out although she showed glycosuria. A year later, November 2, 1952, she came in with a fasting blood sugar of 361 mg. per 100 ml. When I straightened her out on insulin and diet, starting with 20 units NPH insulin, she responded quickly, the blood sugar came down to normal in two days and she has been well controlled on 20 and later on 16, then on 10 units a day.

This shows that even though one may rule out diabetes at any particular time, this is apt to come forth at a later date. The glycosuria alone, when I first saw her, in the presence of blood sugars 74-87-41 certainly could not have been considered as diabetes, even now in retrospect.

Acute Hepatitis and Steroids

Steroids are said to shorten the course in some cases of infectious hepatitis and are more likely to be helpful in severe than in mild cases. Some patients have been made worse. It appears that the cholangiolitic type of viral hepatitis is benefited more than other types.

In general, however, it would appear that steroids should probably not be used in this disease until more information is available regarding results of treatment except perhaps in severe progressive hepatitis.—Kenneth B. Castleton, M. D., Salt Lake City, Utah: *Rocky Mountain M. J.,* 55: 41, August, 1958.

Follow-Up Care Outlined To Maintain Normal Weight

Obesity, like diabetes, is not cured, but controlled. Thus, after attaining normal weight, the patient must be taught how to maintain it. It is unusal for him to lose his excessive desire or compulsion to eat just because he has been on a weight reduction program. The person who tends to gain weight never loses the tendency. Only rarely does a patient who has successfully reduced say: "I no longer have the desire to eat that I used to." With this in mind, the following principles have been established in follow-up care:

(1) The food plan, high protein, low fat, low carbohydrate, and calorically adjusted to individual needs, must be life-long.

(2) The patient must maintain his enthusiasm for normal weight by continuing to be weight-conscious. He should weigh once weekly.

(3) He must see the physician at intervals of every three months for at least a year after normal weight has been maintained.

(4) An anorexigenic agent may be prescribed intermittently to help control appetite. It should be taken during periods of stress or when the patient notices weight beginning to creep up again. Saturdays, Sundays and holidays particularly seem to encourage over-eating.

(5) Physical activity should be maintained just as during the weight reduction program.—Robert H. Barnes, M. D., Seattle, Wash.: *Northwest Med.,* 57:1011, August, 1958.

Cholecystectomy Before and After 48-Hour Optimal Period

At the present time it seems fair to say that the majority of authors agree that cholecystectomy is indicated within the first 48 hours following the onset of an acute attack if the patient's condition warrants surgery, and if proper hospital facilities and well-trained professional personnel are available. It is with reference to the patient whose disease has progressed *beyond* this point that the debate rages. The articles through which the battle has been waged contain reports of mortality and morbidity, and comparisons of results can be obtained by referring to them. A review of typical mortality figures in cases operated upon for acute cholecystic disease at "the optimum time" reveals a range of 2.4 to 3.5 per cent in series containing from 84 to 527 cases. In one recent series of 103 seriously-ill patients treated surgically, the mortality rate was 9.1 per cent.—J. K. MacGregor, M. D., Mason City, Ia.: *J. Iowa M. Soc.,* 48:502, September, 1958.

A Study of *Staphylococcus Aureus* in Akron Hospitals

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THE isolation of the so-called "epidemic strain" of staphylococcus aureus coagulase positive phage type 47C/52/80/81 from adult medical patients in January, 1958, in an Akron hospital prompted an epidemiologic investigation of the incidence of this organism by the Akron Health Department. It had been thought that this epidemic strain of staphylococcus was chiefly a problem for the nursery and the newborn infant. The isolation of this bacterial agent in adults was the first confirmed instance of this problem known to the Ohio Department of Health.

Recent reports from all over the nation have stressed the increasing awareness of the problem of staphylococcus in current medical therapy. With the isolation of the organism in two patients in the Akron area in whom infection was not the primary cause of hospital admission, further investigation from a public health standpoint was thought advisable. The case histories of the two patients were prepared as a preliminary step. These are presented. (This hospital will hereafter be known as Hospital A.)

Case 1. The patient, a male, age 74 years, was admitted to a medical floor on December 14, 1957, with a diagnosis of myocardial infarction. He was afebrile until January 5, 1958, when he spiked a temperature of 102°. A chest x-ray on January 6 revealed an infiltration of the right upper lobe. A sputum culture on January 9 revealed S. aureus coagulase positive phage type 47C/52/80/81. He received penicillin and was discharged on January 13, 1958, improved. He was readmitted January 30, 1958, in coma with thrombophlebitis of the left leg. X-ray of the chest showed pneumonia of all lobes of the right lung. He was treated with Chloromycetin® and penicillin but expired on January 31, 1958.

Case 2. A male patient, age 67 years, was admitted to a surgical floor on January 17, 1958, because of rectal bleeding. He was afebrile on admission. Sigmoidoscopy was performed and on January 20, 1958, a barium enema revealed a filling defect of the cecum. Chest x-ray on this date revealed congestion of both lower lobes and a chronic pneumonic infiltration. On January 22 he spiked a temperature of 103.6° at a time when the chest was clear of rales. A blood culture drawn on January 22 grew S. aureus coagulase positive phage type 47C/52/80/81. He expired suddenly on January 25. Autopsy revealed bilateral pneumonia and acute cerebral infarction.

Since the problem had been known to exist in nurseries, a plan was devised to visit the nurseries of Hospital A and culture all infants over 24 hours of age. This was felt to be a captive population and an efficient way to measure the incidence for the hospital. At the same time, the laboratory of this hospital was requested to send all coagulase positive staphylococci from all patients to the State Department of Health Laboratory for phage typing for their own information. On February 24, 1958, one of us (L.G.D.) visited the nurseries and cultured all the infants as planned. A revisit on March 18, 1958, was also done because of the findings on the first culture group. The data are summarized in table 1.

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TABLE 1.—*Data of Nursery Cultures Hospital A.*

	Negative for Staphylococci	Coag. Pos. Staph. but not 80/81	Epidemic Strain Isolated	Total
Newborn Infants February 24, 1958	19	15*	10**	44
Newborn Infants March 18, 1958	18	12*** 2* 1****	1**	34
Nursery Personnel March 18, 1958	18	2* 1*** 2****	0	23

* untypable
** 47C/52/80/81 or 42 B/47C/52/80/81
*** 44 A
**** Miscellaneous types

The finding of 10 infants with the epidemic strain in the February 24 study was deemed so high that epidemiologic investigation was carried out by a nurse investigator from the U.S. Public Health Service, then working with the Ohio Department of Health, and a Public Health Nurse of the Akron Health Department. In the interval between the first isolation of the epidemic strain in adult patients in Hospital A, other family groups in whom this organism was isolated in newborn infants became known to the Akron Health Department. Accordingly, home visits were made to a total of 12 family groups by the two. The data

TABLE 2.—*Data of First Epidemiologic Study.*

Family	Pathology of baby	Pathology of mother	REPEAT CULTURES DONE March 26, 1958	April 1958	May 1958
1. Ku	Breast abscess	Breast abscess	Baby N-P Neg. Mother N-P Neg.		
2. Roc	N-P carrier 80/81	Breast abscess	Baby N-P Pos.* Mother N-P Neg.	Baby N-P Pos.* Lesion Pos.* Mother N-P Neg.	Baby N-P Pos.* Mother N-P Neg.
3. Ri	Furuncle	Furunculosis	Baby N-P } Pos.* Lesion } Mother N-P Neg.	Baby Lesion Pos.* Mother N-P Pos.*	Baby N-P Pos.* Mother N-P Pos.*
4. Fi	N-P carrier 80/81	Nasal Furuncle	Baby N-P Pos.* Mother N-P Pos.* Lesion Neg.		
5. Pe	Furunculosis	Breast abscess	N-P Pos.* Baby Rash Pos.* Mother Breast Drainage +N-P Pos.*	Baby Lesion Pos.* Mother N-P Pos.* Lesion Pos.*	Baby N-P Pos.* Mother N-P Pos.**
6. McG	Axillary furuncle	None	Baby N-P Pos. 44A Mother N-P Neg.		
7. Da	N-P carrier 80/81	Breast abscess	Baby N-P Pos. 52/80 Mother N-P Pos.*		Baby N-P Pos.** Mother N-P Pos. 44A
8. Ru	N-P carrier 80/81	None	Baby N-P Pos.* Mother N-P Neg.	Baby N-P Pos.*	Baby N-P Pos.* Mother N-P Neg.
9. Bo	Impetigo	None	Baby N-P Neg. Mother N-P Pos.*	Mother N-P Pos.*	
10. Roh	N-P carrier 80/81	None	Baby N-P Pos.* Mother N-P Neg.	Baby N-P Pos.*	Baby N-P Pos.** Mother N-P Pos.**
11. Co	N-P carrier 80/81	None	Baby N-P Pos. U Mother N-P Neg.		Baby N-P Pos. U Mother N-P Neg.
12. Ty	N-P carrier 80/81	None	Baby N-P Pos.* Mother N-P Pos.*	Baby N-P Pos.* Mother N-P Pos.*	Baby N-P Pos. U

(The epidemic strain of staphylococcus is frequently abbreviated by the numerals 80/81)
*—42B/47C/52/80/81
**—47C/52/80/81
U—Untypable strain
Neg.—Negative for staphylococcus aureus
N-P —Nasopharynx
Pos. —Positive for staphylococcus aureus

from these visits are summarized in table 2.

The Pe and Roc families (Case 5 and Case 2) deserve special note. Mr. Pe developed a perineal abscess in June, 1958, which required surgical drainage. A S. aureus phage type 47C/52/80/81 was isolated from this infection four months after the first demonstration of this bacterial agent in the family group. Baby Roc continues to have skin lesions from which the epidemic strain of staphylococcus was isolated on July 9, 1958.

The data compiled after the first epidemiologic study revealed a potentially more serious public health problem than had been anticipated. For this reason the medical staff members of the Health Department presented suggestions to the administrations of the three Akron hospitals in which maternity units are located. At the request of, and with the cooperation of the administration of these hospitals, a study was undertaken to ascertain the degree of "saturation" of the three hospital nurseries with the epidemic strain of staphylococcus.

The purpose of this study was threefold. First, it was deemed important to ascertain exactly how great a reservoir of the epidemic strain of staphylococcus was present in our hospital population. Secondly, it was hoped that by determining how great a potential threat existed, we could institute measures to minimize the problem. And third, we hoped to be able to present the data to the medical community to demonstrate how important this "common contaminant" has become.

Method of Study

It was decided that all newborn infants in the three Akron hospitals would have a nasopharyngeal culture done at the time of discharge from the nursery. Culture materials were to be supplied by the laboratory of the Akron Health Department with the cultures to be taken by the nursery personnel of the individual hospitals. The cultures were to be picked up daily by the Akron Health Department Laboratory and the original bacteriological isolations were to be done by this laboratory.

Cultures were taken using braided picture wire to which a small amount of cotton was applied to one end using collodion. After culturing, swabs were placed in salt broth media (brain heart infusion broth to which 7 grams of salt per 100 ml. of media was added). Incubation at 37° C for 24 hours was done. The salt broth cultures were streaked onto mannitol salt agar (Bacto Phenol Red Agar, Difco Laboratories, to which 7 grams of salt per 100 ml. of media was added). Incuba-

tion was done for 24 hours at 37° C. Mannitol positive colonies were picked and inoculated onto plates of heart infusion agar (no salt added). These were incubated for 18 to 24 hours and used for coagulase testing and sensitivity tests. Those colonies which were coagulase positive were sent to the Ohio Department of Health Laboratory on heart infusion agar slants to which 7 grams of salt per 100 ml. of media was added for phage typing. All phage typing in this study was done by the Communicable Disease Laboratory of the Ohio Department of Health.

Home visits were to be made on all families in which the epidemic strain of S. aureus was isolated by the Public Health Nurses of the Akron Health Department (or the Summit County Health Department for families residing outside Akron limits) at monthly intervals following discharge from the nursery. At the time of the home visit, repeat cultures were to be taken of the nasopharynx of both mother and baby, as well as any other member of the family unit in whom staphylococcal disease were suspected at that time. In addition data were to be compiled concerning any infectious lesions in the family group.

In order to assure that the practising physicians would be aware of the presence of this organism in their patient-families, a letter was to be sent by the health department which served to notify the physician of the presence of the bacterial agent and to give him the antibiotic sensitivity pattern. This was carried out in all cultures done.

The proposed investigation was heartily accepted by the three hospitals and the study began in early April, 1958. During the period of study which ended on May 16, 1958, a total of 1,282 cultures were done. The data are given in table 3.

TABLE 3.

Hospitals	No. of Newborn Cultures	No. Positive for Epidemic Staphylococcus
A	323	2
B	773	30
C	186	14
Totals	1282	46

Results

Of the 1,282 cultures taken, 46 were found to be positive for the epidemic strain. Thirty-four home visits to these family units were made. The data from these visits are presented in table 4.

It is of interest to note that only two positive cultures were obtained from Hospital A, an incidence of 0.6 per cent. In Hospital B, we found 30 positive cultures out of a total of 773, an incidence of 3.88 per cent. There were 14 positive cultures out of 186 in Hospital C, an incidence of 7.52 per cent.

It is also of interest to note that there was much less serious after effects in the family groups studied than in the first investigation in March (table 2). There were five cases of breast abscesses in these 12 families. In the last study group there was one instance of a breast abscess in an infant; the remaining pathological processes were restricted to less severe skin infections.

In addition to the visits made by means of nursery-screened families, the public health nurses of the Akron Health Department investigated 15 family units in whom staphylococcal disease was suspected. These families were encountered in everyday nursing contacts. Sixty-two cultures were done in this group. Thirteen of these were of the epidemic strain of staphylococcus and follow-up visits were made.

That the same bacterial organism can cause varying types of pathology in different persons is well known. This is probably the only explanation for the great incidence of serious pathological processes in our first investigation and the relatively minor morbidity in the second.

Since the conclusion of the study period, we have not been aware of any further difficulty among the newborn infants or their families.

Summary

A study of the incidence of the epidemic strain of S. aureus phage type 42B/47C/52/80/81 and 47C/52/80/81 in the Akron area is presented. Follow-up visits are presented. The study carried out by the health department has resulted in some changes in nursery policy which we feel has been of great help in controlling the spread of this organism.

Better working relationships were achieved between the Akron Health Department and its laboratory and the three hospitals involved in the study. The hospital staffs and administrations were made more aware of the threat of S. aureus for all patients. An infections committee was established in the hospitals as a result of the findings of this study. This will help maintain the high level of asepsis and surveillance which is so necessary in prevention of the spread of infection.

This study served to acquaint the hospitals with the services of the Communicable Disease Research Laboratory which they are continuing to use in staphylococcal disease control.

Acknowledgments: The authors gratefully acknowledge the help given them by the nursing staffs of the Akron Health Department and the Summit County Health Department in making all home visits in this study. Members of the laboratory staff of the Akron Health Department were instrumental in the successful completion of the report by their work in providing culture media and in doing all bacteriological isolations prior to submission for phage typing. Also our thanks to Dr. Frederick H. Wentworth and Dr. Winslow Bashe of the Ohio Department of Health; Mrs. Berttina Wentworth of the Communicable Disease Research Laboratory, Ohio Department of Health, with her staff, did the phage typing.

TABLE 4.—*Summary of Data Obtained from Home Visits.*

Family		Date Original Nursery Culture	Date Repeat Culture	Pathology	Miscellaneous
Hospital *A*	Hi	4- 2-58	B 5-5-58 Pos.*	None	7-1-58 B-Pos.* 7-1-58 M-Neg.
	Ko	5- 4-58	B 6-23-58 Pos.* M 6-23-58 Neg.	None	
Hospital *B*	Ca	4-22-58	B 5-23-58 Pos.*	Eye infection - Rash of chest and abdomen	6-17-58 No further difficulty
	Gu	5-10-58	B 5-14-58 Pos.* M 5-14-58 Neg.	Blebs on abdomen	
	He	5-10-58	B NP 6-5-28 Pos.* Lesion 6-5-58 Pos.*	Eye infection	7-1-58 B-Pos.* 7-1-58 M-Neg.
	Wh	4-27-58	B 6-5-58 Pos.* M 6-5-58 Pos.*	None	7-3-58 B-Pos.* 7-3-58 M-Pos.*
	Bl	5-16-58	B 7-7-58 Pos.* M 7-7-58 Neg.		
	Co	4-17-58	B 5-14-58 Pos. 44A M 5-14-58 Neg.	Rash	
	Va	4-17-58	B 5-19-58 Pos.* M 5-19-58 Pos. U		6-58-B-Pos. U
	Ma	4- 7-58	B 5-6-58 Pos.* M 5-6-58 Pos.*	Impetigo	6-6-58 B-Neg.
	Fa	4-22-58	B 5-2-58 Pos.* M lesion 5-2-58 Pos.*	Infected episiotomy	7-1-58 B-Neg. 7-1-58 M lesion Neg.
	Be	4-28-58	B 5-29-58 Pos.* M 5-29-58 Neg.		7-1-58 B-Neg. 7-1-58 M-Neg.
	Th	4-18-58	B 5-16-58 Pos. U		
	Pe	5-15-58	B 6-1-58 Pos. U M 6-1-58 Neg.	Rash on head	
	Wi	5-16-58	B 6-25-58 Pos. U M 6-25-58 Neg.		
	Ma[t]	4-26-58	B 5-21-58 Neg. M 5-21-58 Neg.		
	Wa	4-19-58	B 5-21-58 Neg. M 5-21-58 Neg.		
	Li	4-25-58	B 6-4-58 Neg. M 6-4-58 Neg.	Pustular dermatitis	
	Ak[t]	4-17-58	B 5-19-58 Neg. M 5-19-58 Neg.	Baby has skin lesion Mother had jaw abscess	
	Tu[t]	4-20-58	B 6-13-58 Pos.* M 6-13-58 Neg.		
	Te[t]	5-13-58	B 6-25-58 Neg. M 6-25-58 Neg.	Baby had erythematous rash; Mother had pustular lesion of face	
Hospital *C*	McL	5-13-58	B 6-10-58 Pos.* M 6-10-58 Pos.*		7-17-58 no evidence of infection
	Sh	5-16-58	B-6-25-58 Pos.* M 6-25-58 Neg. F 6-25-58 Lesion Pos.*	B infection of perirectal area and abscess of neck. M infection of lip. F abscess	8-4-58 no lesions present
	Wi	4-30-58	B 5-29-58 Pos.* M 5-29-58 Neg.	Boils on baby	7-58 baby had abscess of neck, NP & lesion Pos.* Mother neg.
	Sm	4-25-58	B 5-28-58 Pos.* M 5-28-58 Pos.*		Moved—no return visit
	Ne	4-20-58	B 5-16-58 Refused culture M Pos.*		No lesions noted
	Li	4-16-58	B 5-15-58 Pos.*	Lesions on baby's face	6-26-58 Return visit cultures negatives
	Cr	4-22-58	B 6-6-58 Pos.* B 6-6-58 Pos. 44B	Blebs on arm	
	Bu[t]	5-11-58	B 6-11-58 Pos.* M 6-11-58 Neg.		
	Lo	4-30-58	B 6-5-58 Pos. 39/51 M 6-5-58 Neg.	Pustular dermatitis	No return visits made
	Pa[t]	4-21-58	B 5-29-58 Neg. M 5-29-58 Neg.	No lesions	
	Dy[t]	4-26-58	B 5-29-58 Neg. M 5-29-58 Neg.	B skin lesions at 10 days of age	7-58 B has infected rash. M has boils.
	Mi	3- 8-58	B 5-16-58 Pos. U M 5-16-58 Pos. U	Rt. breast abscess in baby	
	Me	5-14-58	B 6-19-58 Pos.* M Refused	Baby had mild pustular dermatitis. Mother had bleb on thigh.	

KEY: (All cultures are nasopharyngeal unless otherwise noted.)
Pos. — Postive for staphylococcus aureus.
Neg. — Negative for staphylococcus aureus.
* — Epidemic strain (42B/47C/52/80/81 or 47C/52/80/81) Other types are given in tables.
U — An untypable strain of staphylococcus aureus.
B — Baby; M - Mother; F - Father.
t — Visits made by Public Health Nurses of the Summit County Health Department.

Exposure Keratopathy

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M.D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

A 29 year old nurse underwent surgery for a parotid malignancy. Unavoidable damage to the 7th nerve was incurred during surgery. This rather prolonged operation was scheduled late in the day, and as a result the semiconscious patient did not return to her hospital ward until evening. She did well and had an uneventful hospital course with one significant exception. Unfortunately the nursing and medical staff failed to realize that the combination of 7th nerve paralysis and postanesthetic lethargy resulted in continuous exposure of her left cornea during the entire night. Within this 12 hour period there resulted sufficient dehydration of the corneal surface and superficial bacterial infection to leave permanent scarring of her central cornea. Simply the instillation of lubricant ointment and closure of her lids would have prevented this tragedy. To this day, her vision O. S. is limited to recognition of the big "E" on the Snellen chart.

Discussion

Exposure keratopathy is one of the most easily preventable forms of eye damage. This ease of prevention is indeed fortunate, since exposure keratopathy is a most common threat to the eye. Any unconscious patient is a potential candidate for corneal damage if his eyes are not closed. This is true whether unconsciousness is from an auto accident, a fall, serious medical disease such as an acute cardiac episode or a cerebrovascular accident, or is iatrogenically induced by anesthesia in the course of a tonsillectomy. A surprisingly short duration of exposure is necessary to cause serious corneal damage. Dramatic evidence of the shortness of this time is repeatedly seen in routine obtaining of corneas for transplantation. As short a time as 30 minutes with open lids renders the cornea unsuitable for transplantation.

Mechanical failure of the lids to close will also result in exposure keratopathy. Exophthalmos is a common cause, and may result from thyrotrophic disorder, orbital tumor, or orbital cellulitis. Ectropion (cicatricial, paralytic, senile, or spastic) may be severe enough to cause localized corneal exposure. Such damaged areas of corneal surface may act as portals of entry for bacterial infection. Bell's palsy is one of the more common causes of chronic corneal exposure. Trauma may leave gaps in lid closure which must be corrected promptly.

The Author

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During all ocular and lid surgery, the operation needs constantly to keep the cornea moist.

Inadequate tear secretion will also cause corneal drying and scarring. The severest cases are seen when the conjunctival goblet cells are destroyed by diseases such as pemphigus, trachoma, Stevens-Johnson syndrome, or extensive chemical burns. Keratoconjunctivitis sicca (dry eyes) is a lesser degree of lacrimal deficiency occurring commonly in arthritic, menopausal females.

Therapy

Therapy is simply protection of the cornea by means of ointment, lubricant drops, bandages, or sutures. Recognition of the need for such protection is the duty of each doctor and nurse. Instillation of 5 per cent boric acid ointment is routine in every general anesthetic at the University Hospital. Such simple care will almost invariably prevent "ether burns of the eye" which may occur without the use of ether at all and usually represent exposure damage due to negligence. Similar treatment is indicated for all semiconscious patients with inadequately closed eyes. Boric acid ointment is chosen because it is cheap and effective and there is no need in these prophylactic circumstances for the more expensive steroids or antibiotics. Eye pads are also effective, but must NEVER be applied dry, as the lids will open beneath the pad and its rough surface will cause severe corneal abrasions. Such a pad must always be well greased and applied to the *closed* lids.

For chronic low grade exposure such as seen in Bell's palsy or thyroid exophthalmos, 1 per

cent methylcellulose is a most useful lubricant drop. This substance is quite viscous and protective, yet is water soluble and nongreasy. It does not produce the misty visual disturbance which is so annoying with ointments.

Prevention of Corneal Exposure

Acute severe corneal exposure such as may be threatened in lid trauma or orbital edema is often best prevented by closing the lids with a mattress suture through their margins. The skin bite should extend at least 3 mm. from the lid margins. A 4-0 suture size is optimal. Depth of the suture should include part of the tarsal plate, with the needle traversing the gray line in the middle of the lid margin. Under no circumstances should the suture emerge on the inner surface of the lid, as this will result in corneal abrasion.

The double-armed suture should pass through and be tied on top of a piece of rubber band in order to prevent cutting through the skin. The lid edges should only be loosely approximated, for a tighter suture will cut through the lid margin, leaving an unsightly notch. Such a lid suture may be left in place for up to a week. Should a longer period of lid closure be necessary, a tarsorrhaphy is necessary. This consists of denuding opposing lid edges of epithelium and suturing them together to obtain permanent adherence.

Eternal vigilance and prophylactic ointment will prevent eye damage from exposure keratopathy!

Mechanism of Action of Oral Diabetic Therapy

1. The active sulfonylurea compounds, in general, exhibit a blood sugar-lowering effect which depends, within limits, on the dosage.

2. The sulfonamide group, apparently, is the most active, although many methyl-ethyl-hexyl compounds could be employed with much less success.

3. Little effect is seen in cases of diabetes following pancreatectomy, or in patients with genuine insulin insensitivity, or in the hyperglycemia after adrenalin and glucagon.

4. These drugs probably do not act by inhibiting glucagon secretion and damaging the alpha cells. There is little evidence that they act by depressing insulin antagonists. It is pretty clear that the sulfonylureas, including Orinase, can depress the action of the hepatic enzyme systems which operate upon the transformation of such substances as fructose to glucose. They probably inhibit the action of the proteolytic enzymes known as insulinase, although this effect has not been confirmed.—Howard F. Root, M. D., Boston: *North Carolina M. J.,* 19:293, August, 1958.

Early History of Therapeutic Use of Tobacco

Many of the early synonyms for *Nicotiana* bear witness to the supposed therapeutic virtues of the plant: *Herba Panacea; Herbe propre á tous maux; Heilkraut.* The pharmacopoeias, official or unofficial, invariably included *Tabacum* (indeed, as late as the United States Pharmacopoeia of 1890), although by the 18th Century it had already been noted that tobacco was even then used more for amusement than for its medicinal virtues (Alston, 1770); and by the early 19th Century, the potential dangers of tobacco as a drug were well known. . . .

In former years, tobacco was recommended as a remedy for relief of asthma on account of its antispasmodic effects (W. S. Thomas, 1928). "In disordered respiration," wrote Sigmond (1838f), "this herb obtained the well-merited confidence of the older physicians, in cases [of spasmodic asthma] where no organic alteration has occurred. It has, however, nearly fallen into neglect, from which state it will most probably revive, for it has lately been tried to a very great extent, and with no small success, under a false name [a spirituous tincture of the tobacco having been supplied to physicians under the name of *Lobelia inflata,* which latter drug was then in great demand]. My own experience had led me to its frequent employment; nor did I discover for some time the artifice which had been practiced. It, however, induced me to place great reliance on the aetherial tincture of tobacco, to mitigate the paroxysms of spasmodic asthma. It must, however, be remembered that where the lungs are diseased, it is capable of exacerbating the complaint, and that it always demands the careful discrimination and judicious watchfulness of the medical man." Sée (1869) also held that the actions of tobacco were antagonistic to asthma; hence, he recommended the moderate use of tobacco by asthmatics but at the same time cautioned that immoderate use provoked attacks. P. Smith (1890) recorded the case of a woman who had used tobacco for years for the relief of asthma, who eventually developed tobacco amblyopia.

The mixture of tobacco and leaves of the thorn apple *(Datura stramonium)* has, from olden times, been used as a remedy for asthma in the form of so-called "asthma cigarettes." Lickint (1925c) believed that the nicotine of the tobacco weakened rather than reinforced the bronchial antispasmodic action of *Datura stramonium,* and therefore, advised inhaling the smoke of burning stramonium leaves alone.—H. Silvette, Ph. D., et al.: *Virginia M. Monthly,* 85:472, September, 1958.



THE Committee on Maternal Health proudly presents this, its initial annual report. It consists of a Maternal Mortality Study covering the 88 counties of Ohio for the year 1955. The statistics have been compiled and are published in compliance with a House of Delegates directive adopted April 23, 1953, creating this Committee; and follow-up action taken by The Council on January 16, 1954.[1]

As prescribed, the activities of the Committee are statistical and educational. They consist of:

1. The operation of a voluntary, scientific study of all maternal deaths in Ohio, assisted by various agencies, organizations and individual physicians of the state.*

2. The maintenance of an education and training program for Ohio physicians pertaining to the practice of obstetrics. Material for the project is selected from data and experiences gained from the Ohio Maternal Mortality Study, and is applied in the following phases:

a. Publication of the "Maternal Health in Ohio" column, *The Ohio State Medical Journal,* on a monthly basis, beginning with Volume 52, September, 1956.*

b. Support of a program operated by the Ohio Society of Anesthesiologists to train physicians in the administration of proper anesthesia for use upon obstetrical patients.

c. Provision of minimum, uniform standards of obstetric care through "Guiding Principles for Obstetric Care,"[2] published by the Committee, and approved by The Council.

d. Preparation of data and information on various phases of obstetric management, for use by various local medical groups throughout the state. These include outlines as well as visual aids.

3. The Committee acts as an advisory body to

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

TOPIC THIS MONTH:

Maternal Mortality Report For Ohio—1955

The Council in matters pertaining to Maternal Health in Ohio.

Terminology and nomenclature used herein have been adopted after prolonged study. For the purpose of uniformity, certain nomenclature follows that employed in The Manual of the International List of Causes of Death.[3] All terms and nomenclature have been published previously,[1] and will not be reviewed at this time.

The statistics for 1955 are presented logically and concisely to enable the reader to compare this report with similar documents in the future. Additional reference will be made to this data in subsequent issues, at which time they may be elaborated upon.

Ohio Maternal Mortality Study Statistics for 1955

Total live births in Ohio, 1955	**222,689**
Total cases studied	119
Cases not studied due to lack of information	2
Maternal Deaths (classified)	**96**
White	77
Non-white	19
Age:	
Teens	8
20's	37
30's	40
40's	11
Parity:	
Primigravidae	29
Multiparae	65
Unknown	2
Place of death:	
Hospital	89
Other	6
Not known	1
Method of Delivery:	
Operative	52
Nonoperative (spontaneous)	26
Not delivered (incl. postmortem deliveries)	18
Route of delivery:	
Vaginal	57
Cesarean: (ante mortem)	21
(postmortem)	7
Not delivered	11

Case classification: (when death occurred)		
Group I (fr. concept. to 20th wk.)	6	
Group II (fr. 20th up to 28th wk.)	0	
Group III (fr. 28th wk. through term)	10	
Group IV (postabortal, postpartum)	80	
Autopsies	58	
(Coroners cases, 14)		
Classification of preventability:		
Nonpreventable	46	
Preventable	50	
Patient Responsibility (P_1)	11	
Personnel Responsibility (P_2)	33	
Both (P_1 and P_2)	6	
Prenatal Care (Apparent from data sheets)		
Adequate	55	
Inadequate	15	
None	12	
Excluded (ectopic preg. and abortion)	5	
Not reported	9	

Classification of Primary Causes of Death:

Hemorrhage		**15**
Abortion	1	
Abruptio	1	
Afibrinogenemia	1	
Ectopic pregnancy	4	
Laceration	3	
Placenta Praevia	3	
Postpartum (atony, etc.)	1	
Ruptered uterus	1	
Infection		**12**
Abortion, septic (including alleged "criminal abortion")	9	
Puerperal (true)	2	
Other: Peritonitis (non-puerperal)..		
Tuberculosis		
Up. Resp. Inf.	1	
Toxemia		**9**
Chronic Hypertension (including hypertension with cerebrovascular accident)	2	
Eclampsia	5	
Pre-eclampsia	2	
Other		**60**
Amniotic fluid embolus	6	
Anesthesia (General)	8	
Anesthesia (Regional)	6	
Blood dyscrasias		
Cardiac disease	11	
Cerebrovascular accident (no hypertension)	6	
Diabetes	3	
Liver diseases	3	
Lower nephron nephrosis	2	
Malignancy		
Pulmonary embolus	8	
Renal disease	1	
Other (suicide, psychosis, respiratory failure, etc.)	6	

In Ohio, there were 222,689 live births reported for the year 1955. From this study, classifying 96 maternal deaths for the year, the maternal mortality rate was 0.431 per 1,000 live births, or 4.31 per 10,000 live births.

Discussion

The Committee reviewed every case thoroughly and studied the facts and data. Final classification of each case was made solely upon available information. In many cases this was abundant, but in some it was extremely meager. The minimum standards prescribed in "Guiding Principles for Obstetric Care" were used as a guide to grade preventability in each case. An effort was made to render a final opinion which was justifiably correct. Of the 121 cases received, two could not be completed due to a lack of available information at county level. The great majority of deaths, 65, occurred among multiparae, and there were only 58 autopsies in the 96 maternal deaths. Fifty-two per cent of the maternal deaths were voted preventable on the basis of the data available.

Under Primary Causes of Death, hemorrhage led with 15. It is interesting to note that 60 of the 96 maternal deaths were due to conditions *other* than hemorrhage, infection or toxemia.

Among these "Other Causes," anesthesia was responsible for more deaths than was any other individual category. It was also higher than infection or toxemia, which caused 12 and nine deaths, respectively. This would indicate a need for further education in the field of obstetric anesthesia.

Cardiac disease with 11, and pulmonary embolus with eight, were the next most frequent causes of death under "Other Causes."

Future Plans

The Committee recommends that this project with its many phases be continued with renewed vigor, to reduce further maternal mortality (and morbidity) in Ohio. Plans are being made to tabulate and publish similar statistics each year so as to portray accurately the problems and difficulties encountered in obstetric practice in Ohio. This will be accomplished by a use of uniform nomenclature and classification of maternal deaths. To achieve this goal, however, the Committee encourages an improvement in case records written by personnel who attend obstetric cases throughout the state.

The Committee gratefully acknowledges the assistance afforded by attending physicians, representatives of the various County Medical Societies, the Ohio Department of Health, and other organizations. Without their untiring cooperation this study could not have been compiled.

Respectfully submitted,

ANTHONY RUPPERSBERG, JR., M. D., *Chairman*
Committee on Maternal Health.

Approved by The Council of the Ohio State Medical Association, September 14, 1958.

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A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 49 year old white female entered University Hospital, Columbus, Ohio, with the chief complaint of acute abdominal pain of three days' duration. She had a history of tonsillectomy at the age of 15, appendectomy and tubal ligation when she was 19, and a cholecystectomy at the age of 24, following which she had avoided greasy foods as these tended to cause nausea and vomiting. For many years she had suffered from biweekly episodes of left frontal headache with occasional photophobia, followed by severe nausea, vomiting and upper abdominal pain.

At the age of 34 she had another laparotomy, for unknown reasons, and was told that she had many adhesions. Some years ago an abscess around the rectum had to be incised, resulting in an anal stricture which caused constipation and required frequent enemas. In the past year her attacks of headache, nausea and vomiting had become more frequent and lasted from one to several days. Three weeks ago she was hospitalized in her local hospital for similar complaints and was told that she had a scarred duodenum on x-ray examination. She had a barium enema and had been passing blood and mucus from the rectum several times daily since. She left her local hospital after two weeks feeling vaguely unwell.

Four days prior to admission to University Hospital she developed a severe noncramping lower abdominal pain together with a severe lumbar and sacral pain. This latter pain caused much distress, sleeplessness, nausea and vomiting. She had eaten almost nothing in the past three days since the intake of food was followed by vomiting and also aggravated the abdominal pain. She apparently had always been of a nervous disposition, and had amenorrhea since age of 36. The patient was married, had no children. Her family history was noncontributory.

Physical Examination

The patient was well developed, well nourished and appeared in acute distress. She was pale, dehydrated and heavily narcotized. Her temperature was 98° F., pulse 104, blood pressure 120 over 85 and respirations 40. The skin was cold and dry, her lips slightly cyanotic. The chest was clear to percussion and auscultation. The heart showed no murmurs and was not significantly enlarged. The abdomen showed moderate diffuse distention, with hypoactive bowel sounds and generalized tenderness to deep palpation, which was more marked over both upper quadrants. The rectal sphincter was stenosed.

Presented by

- **Henry E. Wilson, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Laboratory Data

Her hemoglobin was 12.7 Gm.; hematocrit 39 per cent; white blood cells 16,700 with 84 per cent polymorphonuclear leukocytes. The urinalysis showed 3 plus sugar and was positive for acetone. Serum amylase was 85 units; sodium 144 mEq., potassium 4.0 mEq., chlorides 107 mEq.; CO_2 combining power was 39 vol.; blood urea nitrogen 19 mg.; prothrombin 29 per cent; total plasma protein 5.3 Gm. (albumin/globulin ratio 3.6/1.7). Thymol and van den Bergh were negative. The blood sugar was 110 milligrams.

Roentgenographic Data

There was no evidence of active cardiac or pulmonary disease. The ascending colon was moderately distended and showed several fluid levels. Some small bowel loops appeared filled with fluid and gas, and two days later fluid could be recognized in the peritoneal cavity. Subsequent upright and supine films of the abdomen showed a moderate amount of air without evidence of fluid levels in the stomach and small bowel.

Hospital Course

Her abdominal pain remained essentially unchanged. Constant gastric suction was carried out and she received intravenous fluids containing vitamin B and potassium supplements. Her abdomen became silent and she stopped passing flatus.

Surgery was considered undesirable in view of the patient's general condition and a pulse rate of 120. An abdominal paracentesis yielded 20 cc. of serosanguineous fluid which had an amylase content of 124 units. Malignant cells were not observed in this material. Frequent blood counts revealed a drop in hemoglobin to 7.7 Gm., a hematocrit of 24 on the second hospital day, and a rise in white blood cells to 24,800 with 74 per cent polymorphonuclear leukocytes.

She received several units of whole blood and the hemoglobin rose to 10.8 Gm., while her white blood count dropped to 12,000. On her third hospital day her abdomen was becoming distended and tympanitic with absent bowel sounds and more marked guarding, especially over the left upper quadrant. Large amounts of brownish fluid were being aspirated via Levin tube. Blood transfusion was continued, together with intravenous fluids. She complained much of thirst.

On the fifth day she appeared more alert with some decrease in abdominal distention. However, she developed asthmatic type of dyspnea and crackling rales over the lung bases. She was placed in an oxygen tent and given aminophylline intravenously. Her respiratory distress continued, although it improved for short periods with symptomatic treatment. On the morning of her sixth hospital day the abdominal findings were much improved: She was less distended and the tenderness on the right side of the abdomen had practically disappeared. However, she still had fullness and tenderness on the left side and bowel sounds were still absent.

Her dyspnea continued, her pulse was 140, and she had diffuse rales and rhonchi over both lungs. A 500 cc. phlebotomy was done and was followed by moderate relief lasting approximately an hour. Thereafter she became quite incoherent and her temperature went to 103° F. She remained in respiratory distress, became irrational and died on her seventh hospital day.

Clinical Discussion

DR. WILSON: This patient came in with a chief complaint of acute abdominal pain of three days' duration. She had had many operations in her younger years, and as you go a little bit further with her history you get some clues as to why she had so much surgery. For many years she had suffered from episodes characterized by left frontal headache with occasional photophobia followed by nausea and vomiting. This sort of thing makes you think of brain tumor or a congenital aneurysm, but most of you think first of a migraine syndrome with a persistent abdominal component.

Closely related to it symptomatically is a condition known as biliary dyskinesia, which is explained as some autonomic imbalance in the biliary physiology. These people have right upper quadrant pain, often with nausea and vomiting, and often with migraine headaches. One may take his choice: One may call this biliary dyskinesia with headaches or migraine with a biliary component, or look for some organic disease.

It is clear that her doctors were impressed with her symptoms since they took out her gallbladder at the age of 24. There aren't many things for which you take out the gallbladder at that age. Probably the commonest condition is cholelithiasis with serious attacks or hemolytic syndromes. If the latter are serious enough, about 60 per cent develop gallstones in their early twenties and require cholecystectomy. In the old typhoid days young people used to get gallstones commonly. Nowadays gallstones at the age of 24 are rather uncommon.

Ten Years Later

And ten years later she had another laparotomy and you can bet your bottom dollar that she was complaining of another abdominal pain with nausea and vomiting. They only found many adhesions, which is not surprising. She had not menstruated since the age of 36, but about the time of menopause migraine patients either get a whole lot worse or frequently much better.

Three weeks prior to her admission she was hospitalized for similar complaints and I presume that means nausea, headache and vomiting. Something happened apparently at about the time of her barium enema because for the first time she commenced having stools with blood and mucus. It would be nice to know whether she was passing a lot of blood and mucus or whether she was dribbling a little bit of mucus as people often do with proctitis. From now on things went from bad to worse. She left that local hospital feeling vaguely unwell, and then four days prior to admission here she developed this severe low abdominal noncramping pain.

We are going to lay great emphasis on the noncramping character and the fact that it was both front and back, in the lower abdomen, and radiating through to the lumbar and sacral area. It caused much distress, sleeplessness, nausea and vomiting. She had not been eating since food intake was associated with exacerbation of the pain. The vomitus was clear and not bloody.

Now on physical examination she appeared badly dehydrated and rather cyanotic. The ab-

domen was diffusely distended and the bowel sounds were hypoactive. She was tender to deep palpation. I am not sure why she had this more marked tenderness over the upper quadrants unless perhaps it was associated with muscle tenderness due to her protracted vomiting.

Her laboratory tests showed a leukocytosis, a normal serum amylase, and normal electrolytes. She had 3 plus sugar and a positive acetone in her urine, and in view of a blood sugar of 110 mg. I am willing to call this a stress glycosuria and think that her acetone was probably due to her protracted vomiting. Her x-ray examination showed her abdomen filling with fluid and some of her intestines distended with gas and fluid.

Her hospital course went from bad to worse. The pain remained unchanged. She was treated with narcotics and analgesics. Her temperature rose and she developed a paralytic ileus. The surgical consultant declined to intervene because of the patient's general condition, and an abdominal paracentesis yielded some serosanguineous fluid which had an amylase content below the levels significant of acute pancreatitis.

Now it is apparent at this point that the patient was losing blood somewhere. In spite of her dehydration she was dropping her hemoglobin, had a low hematocrit, and about this time or soon afterwards she became jaundiced. So we have to consider here the possibility that she was either hemolyzing her blood or that she was bleeding into the bowel and/or into the peritoneum. We know that some blood was being lost into the peritoneum because of the serosanguineous paracentesis fluid, and we might postulate that these bloody stools were much more voluminous than we had suspected heretofore. She also developed quite a marked leukocytosis, and it took 3 units of whole blood to bring her hemoglobin back up to 10.6 Gm.

Thirst

She remained quite tender in the abdomen and complained of thirst. I suspect that hypochloremia may be the reason for her thirst. As you know, you can fill people full of water and if their chloride level or their sodium level is low they will still be thirsty.

On the fifth day she seemed to improve a little bit but then had an acute attack of respiratory distress. It may have been that she was on the verge of congestive failure, perhaps due to a lot of parenteral fluid, and we see that fairly commonly whenever we keep on pouring in the fluids. We think we are using due caution, we listen to the lung bases, and then suddenly it becomes apparent that the patient's lungs are full of fluid. That happens more frequently than we like to admit. Then there is the possibility that she formed an embolus or developed a pulmonary thrombosis.

At any rate she was markedly congested and developed a cardiac type of asthma only temporarily relieved by aminophylline and a venous section. In spite of all these efforts the respiratory distress continued and we can suggest of course that she had a silent coronary attack with congestive failure. On the morning of the sixth hospital day the abdominal findings were improved for a time. She was less distended but she still had a silent abdomen, she was still short of breath and had tachycardia. She suddenly developed one of these acute phenomena which are associated with ruptured heart, ruptured aorta or a massive embolus. She suddenly tensed up, went into a spasm and expired.

But I am going to follow my original hunch and state that this woman had migraine with abdominal complaints. The surgeons fell for it and took her gallbladder out and then did another exploratory laparotomy, but her serious illness developed later.

Thrombosis

I think first and foremost I will suggest mesenteric vascular thrombosis, and we have the choice of whether it was arterial or venous. I think we are more conscious of arterial thrombi because they are almost always associated with easily recognizable cardiac disease leading to embolization or with extensive arteriosclerosis. This woman had neither. This woman was having bloody stools and several days later commenced to have abdominal pain. Now the insidiousness of this is more consistent with a venous thrombosis than with an arterial thrombosis. That I think could account for serosanguineous exudate, the fluid in the unaffected part of the bowel, and her downhill course, and the only thing we must explain is why she should have developed a venous thrombosis. I find no good reason for it and anything that I suggest is going to have to be purely imaginative.

We could conjure up a story for a perforated viscus here. She had a scarred duodenum. She might have had a comparatively asymptomatic ulcer. She had so many abdominal complaints that a lot of things could be readily missed. I don't think she had a perforated viscus or ulcer because she had no air in the abdomen, and I think that on paracentesis they would have found a purulent peritonitis instead of a serosanguineous peritonitis.

The physicians thought about pancreatic disease, and recurrent pancreatitis could account for

a lot of her abdominal complaints. But we are confronted with all these normal amylase determinations. You could think of a bowel obstruction on the basis of old operative adhesions. This is a very important point, but I was taught by some excellent gastroenterologists that until proven otherwise adhesions don't cause bowel obstruction. In any large gastrointestinal service you will find patients with their bellies looking like a battlefield, who are being operated upon again and again to relieve the adhesions caused by the previous surgery. But there are exceptions and this patient may have had a partial obstruction that we all missed. She certainly could have had postoperative adhesions; goodness knows she had enough operations.

Enlarged Spleen

I am going to pass up abdominal aneurysm and retroperitoneal abscesses or lymphoma despite the enlarged spleen I can't account for. As far as metabolic disease is concerned, I don't think she had diabetes mellitus. Most of you have seen persons in diabetic ketosis who have serious abdominal pain and have died from having had a laparotomy when their diabetic ketosis was not recognized. Again many patients are operated on for pains of acute intermittent porphyria, which I don't believe this woman had.

So I am unable to explain the diagnosis of mesenteric thrombosis except to think of something which seems completely unfounded and for which we have not a single good argument. I am going to say that she suffered from a primary cancer of the tail of the pancreas and that the thrombogenic factor associated with this disease was responsible for her mesenteric thrombosis.

Clinical Diagnosis

1. Abdominal migraine.
2. Multiple operations with abdominal adhesions.
3. Mesenteric vein thrombosis with infarction of bowels and paralytic ileus.
4. Acute congestive failure.
5. Carcinoma of tail of pancreas.

Pathological Diagnosis

1. Portal vein thrombosis.
2. Thrombosis of splenic and mesenteric veins.
3. Multiple postoperative adhesions.
4. Infarction of the jejunum.
5. Infarction of the spleen.

Pathological Discussion

DR. VON HAAM: The peritoneal cavity contained about 600 cc. of a hemorrhagic ascitic fluid. There were numerous fibrous adhesions between the bowel, the liver and the parietal peritoneum. The heart was normal, and the lungs showed atelectasis and acute congestion. The spleen weighed 575 grams and showed multiple infarcts. The splenic veins were thrombosed. The esophagus and stomach appeared normal. Sixty-two inches of the small bowel distal to the ligament of Treitz were deeply discolored, distended, and filled with dark red blood. All veins were thrombosed and the thrombi also extended in the large superior mesenteric vein, the portal vein and the liver. The colon was distended and filled with thin, black fecal material. The retroperitoneal and pelvic organs appeared normal.

Microscopic Examination

Microscopic examination showed thrombi in the portal vein and the mesenteric veins which already had begun to organize and were probably 6 to 10 days old, together with many more recent thrombi. Some of the vessel walls showed a very mild inflammatory reaction. The wall of the small intestine showed the typical picture of venous infarction with severe submucosal hemorrhage and less extensive mucosal necrosis. The liver and kidneys showed toxic degeneration. The pancreas was perfectly normal.

In summary then, the autopsy confirmed Dr. Wilson's principal diagnosis of mesenteric vein thrombosis with infarction of the bowels and paralytic ileus. The cause of the thrombosis appeared to be dense adhesions extending to and surrounding the portal vein from the ligament of Treitz, and the thrombotic process was a slowly progressive one involving more and more vessels as the days passed. The blood loss Dr. Wilson mentioned could be explained by hemorrhage into the lumen of the infarcted bowel.

The patient's respiratory distress was partly due to atelectasis caused by a high diaphragm, partly due to toxic shock with circulatory failure and pulmonary edema. Adhesions do not often embarrass the portal circulation, and it may be that a temporary volvulus, no longer recognizable at autopsy, started the whole process off. Once started, it progressed and spread until a large portion of the mesentery and intestines was involved, causing paralytic ileus, hemorrhagic peritonitis and fatal toxemia.

APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1959 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, O., APRIL 21-24

1. Title of Exhibit: _____

2. Name(s) of Exhibitor(s): _____

_____

Institution (if desired): _____

City _____

3. Description of Exhibit: **(Attach 200 word description to this blank)**

4. Exhibit will consist of the following: (Check which)

Charts and posters _____ Photographs _____ Drawings _____ X-rays _____

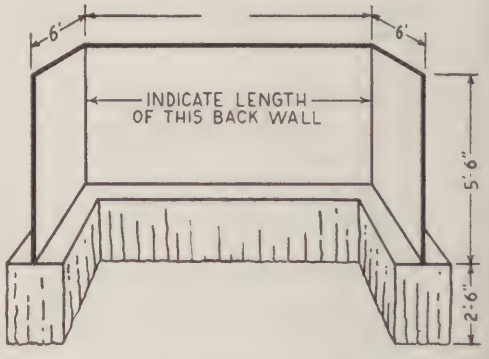
Specimens _____ Moulages _____ Other material _____
(Describe)

5. Booth Requirements:

Length of back wall needed? _____

Square feet needed? _____

Shelf desired? (yes or no) _____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

6. Transparency Cases:

Needed? (yes or no) _____

If answer "yes," give following information:

Number of transparencies to be shown and size of each _____

_____

_____

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association."

Date _____

_____
Signature of Applicant

_____
Mailing Address, Street

_____
City, Zone, State

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO

Preview of 1959 Annual Meeting . . .

Event Will Be Coordinated with 125th Anniversary Celebration of the OSU College of Medicine; Unique Scientific Program Is in the Making

TWO outstanding events of 1959 will be coordinated to give Ohio physicians a unique and outstanding program. These events are the Annual Meeting of the Ohio State Medical Association and the 125th Anniversary Celebration of the Ohio State University College of Medicine. The dates are April 21-24, 1959, with most program features in the Veterans Memorial Building, Columbus.

Dr. Charles A. Doan, dean of the OSU College of Medicine, has named a special committee to work with the State Association's Committee on Scientific Work in arranging the program.

This and other committees of the OSU College of Medicine Celebration are named later in this article. The OSU College of Medicine 125th Anniversary Celebration will continue into Saturday, April 25. Events on that day will be on the OSU Campus.

Another event that will add interest to the Annual Meeting program is additional coordination of the program with meetings of the Ohio State Heart Association and the Ohio Division of the American Cancer Society. These organizations are holding programs on Tuesday, April 21. Scientific and Technical Exhibits of the Annual Meeting will be open on that day as well as on Wednesday, Thursday and Friday.

Here is a gist of the four-day program arranged in chronological order:

TUESDAY, APRIL 21

8:30 A.M.

Registration opens.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

Program to be sponsored by the Ohio Division, American Cancer Society.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M

Continuation of program.

2:00 to 3:00 P.M.

General Session.

Program to be sponsored by the Ohio State Heart Association.

General Session.

Program to be sponsored by the Ohio Division, American Cancer Society.

3:00 to 3:30 P.M

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of programs.

WEDNESDAY, APRIL 22

8:30 A. M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

Section meetings:

Combined session of the Section on General Practice, Section on Internal Medicine and Section on Surgery.
Section on Ophthalmology.
Section on Nervous and Mental Diseases.
Section on Urology.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of section meetings listed above.

2:00 to 3:00 P.M.

General Session.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

General Session.

7:30 P.M.

Annual Banquet.

THURSDAY, APRIL 23

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

Section meetings:

Combined session of Section on Pediatrics and Section on Physical Medicine.
Combined session of Section on Anesthesiology and Section on Obstetrics and Gynecology.
Combined session of Section on Otorhinolaryngology and Section on Radiology.
Section on Neurological Surgery.
Section on Industrial Medicine.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of section meetings listed above.

2:00 to 3:00 P.M

General Session.

(Continued on Next Page)

(Continued from Preceding Page)

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

General Session.

FRIDAY, APRIL 24

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

Program to be presented by the faculty and alumni of Ohio State University College of Medicine as part of College's 125th Anniversary.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of General Session.

2:00 to 3:00 P.M.

General Session.

Program to be presented by the faculty and alumni of Ohio State University College of Medicine.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of General Session program.

5:00 P.M.

Adjournment.

OSU Committees Named

Here are the committees announced by Dr. Charles A. Doan, dean of the College of Medicine, in connection with the 125th Anniversary of the College and the OSMA Annual Meeting:

Steering Committee — Cyril T. Surington, M. D., Chairman, President, Medical Alumni Association; Robert J. Murphy, M. D., Secretary, Medical Alumni Association; Thomas E. Rardin, M. D., President-Elect, Medical Alumni Association; Charles A. Doan, M. D., Ex-officio; Richard L. Meiling, M. D., Ex-offico.

Scientific Program of the OSMA—125th OSU College of Medicine Anniversary Joint Program—April 24, 1959—Dr. Robert M. Zollinger, Chairman; Dr. Zeph J. R. Hollenbeck, Dr. Samuel Saslaw, Dr. Miner W. Seymour, Dr. Dwight M. Palmer, Dr. N. Paul Hudson, Ex-officio.

Committee on 25-Year History for the 125th Anniversary and Medical Alumni Reunion—Dr. N. Paul Hudson, Chairman and Editor-in-Chief; Dr. Linden F. Edwards, Dr. Chauncey D. Leake, Dr. Jonathan Forman, Dr. Rollo C. Baker, Dr. B. K. Wiseman, Dr. Earl H. Baxter, Dr. Philip J. Reel, Dr. John W. Means, Dr. William N. Taylor, Dr. Russell G. Means.

125th Anniversary Celebration—Friday Night Banquet—Dr. Robert J. Murphy, Chairman; Dr. Clark P. Pritchett, Mr. John B. Fullen, Dr. Rollo C. Baker, Miss Mildred E. Newton, Mr. Frederick Stecker, Medical Student Representative, Nursing Student Representative.

Alumni Day Program, April 25, 1959—Dr. Ernest W. Johnson, Chairman; Dr. Clark P. Pritchett, Dr. Cyril T. Surington, Dr. Robert J. Murphy.

American College of Physicians Announces Series of Courses

The American College of Physicians has announced a series of postgraduate courses to be held at various places. Additional information may be obtained by writing to the college at 4200 Pine Street, Philadelphia, Pa. Courses scheduled in the near future are the following:

Congenital Heart Disease, November 17-22, the Johns Hopkins Hospital, Baltimore; Dr. Helen B. Taussig, director.

Internal Medicine — Especially Therapeutics, January 12-16, University of Illinois College of Medicine, Chicago; Dr. Harry F. Dowling, director.

Current Research in Endocrinology, February 2 - 4, National Institutes of Health, Bethesda, Maryland.

Recent Advances in Cardiovascular Diseases, February 9-13, Mount Sinai Hospital, New York City; Dr. Charles K. Friedberg, director.

Recent Advances in Internal Medicine, February 23-27, Pennsylvania Hospital, Philadelphia, Pennsylvania.

Medical Assistants Society Plans 1959 Meeting, May 1, 2, 3

At a recent meeting of the board of directors of the Ohio State Society of Medical Assistants in Cincinnati, arrangements for the 1959 annual meeting of the society were discussed. The meeting will be at the Netherland-Hilton Hotel, Cincinnati, May 1, 2, and 3.

Plans were initiated to draft a "model" constitution and by-laws for local societies which can be used by the local societies as a guide for revising their constitution and by-laws or by those meeting to form a new medical assistants society.

It was voted that all local societies should work on a fiscal year from May 31 to June 1, the same as the fiscal year of the state society.

Proceedings of The Council . . .

Heavy Docket Handled at Granville Meeting; Committee Reports Received; New and Simplified Insurance Blank Will Be Distributed

THE Fall meeting of The Council was held at the Granville Inn, Granville, Ohio, September 12, 13, 14, 1958. All members of The Council were present except Dr. Robert E. Hopkins, Coshocton, Councilor of the Seventh District. In addition to the officers and Councilors the following AMA delegates attended: Dr. Charles L. Hudson, Cleveland; Dr. C. C. Sherburne, Columbus; Dr. L. Howard Schriver, Cincinnati; and Dr. Paul A. Davis, Akron. Also attending, by invitation, were Dr. Robert E. Reiheld, Orrville, chairman of the Committee on Rural Health; Dr. Frederick P. Osgood, Toledo, chairman of the Committee on Public Relations and Economics; Dr. Merrill D. Prugh, Dayton, Ohio chairman, American Medical Education Foundation; Dr. Anthony Ruppersberg, Columbus, chairman of the Committee on Maternal Health; Mr. Charles H. Coghlan, Columbus, executive vice-president of Ohio Medical Indemnity, Inc. Others present were Mr. Wayne E. Stichter, Toledo, legal counsel, and members of the staff of the Columbus office.

By official action, The Council approved the minutes of the meetings of The Council held on June 7 and 8, 1958.

Membership Data

The Executive Secretary reported on membership matters as follows: OSMA membership as of September 10, 1958—9,079; compared to a total membership of 9,070 members as of December 31, 1957. Members of the OSMA affiliated with the AMA as of September 10, 1958—8,072; compared to a total of 8,030 who were 1957 AMA members.

Pro-Rating and Waiver of Dues

By official action, The Council **approved** the following policy applying to pro-rating and waiver of dues for the calendar year 1959:

"1. **Pro-rating of dues for new regular members:** Dues for new members affiliating during the last six months of the calendar year 1959, namely, July 1 to December 31, inclusive, shall be $12.50. Pro-rating of dues shall not apply to former members re-affiliating.

"2. Annual Ohio State Medical Association dues for a physician serving a hospital internship or residency during the first five years following graduation from medical school (excepting the time spent in military service), who meets the membership eligibility requirements of the Ohio State Medical Association and who is accepted into membership by a component medical society, shall be $7.50. Such intern or resident member shall be offered a subscription to *The Ohio State Medical Journal* at one-half the regular subscription rate.

"3. The following procedure shall apply with respect to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

"1. State Association dues for 1959 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

"2. State Association dues for 1959 shall be waived for physicians who were members of the Association in 1958 and who enter such services during the calendar year 1959 before the payment of 1959 dues.

"3. A refund of membership dues will not be made if a member enters such services in 1959 after his 1959 dues are received at the Columbus Office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus Office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

Social Security Poll

The Council approved the procedure outlined for a poll of the membership on the question, "Should physicians be included in the Federal Social Security Program?", such poll to start October 1 and to end October 31. The Council, by official action, authorized the President to appoint a committee of tellers for this project. Dr. Woodhouse **appointed** as tellers Doctors Robert M. Inglis, Perry R. Ayres and Philip B. Hardymon of Columbus to work with the Columbus Office staff on this detail.

Additional Office Space Rented

On recommendation of the Executive Secretary, The Council considered enlarging the Columbus Office by renting space adjoining the present offices in the Hartman Theater Building, available on

or about October 1. After due consideration, The Council **authorized** the rental of the additional space.

Resignation of Dr. Jonathan Forman as Editor

The Council then went into executive session at which The Council was advised by Dr. Woodhouse that he, President-Elect Mayfield and Past-President Martin had conferred on last August 3 with Dr. Jonathan Forman, editor of *The Ohio State Medical Journal,* with regard to the increasing confusion and misunderstanding which have developed because of the conflict between the publicly expressed views of Dr. Forman, opposing fluoridation of public water supplies and the official pronouncements of the Ohio State Medical Association favoring fluoridation.

Dr. Woodhouse reminded The Council that this same question had been discussed with Dr. Forman at a meeting of The Council last December.

Dr. Woodhouse advised The Council that Dr. Forman at the August 3 conference said he would submit his resignation as editor of *The Journal* to The Council at the Granville meeting on September 13-14.

The Council then considered a lengthy written statement from Dr. Forman in which he reviewed his views on fluoridation and his activities in opposition to fluoridation. In the statement he offered to resign as editor of *The Journal* if The Council considered such action advisable.

After a discussion in detail by all members of The Council, **Dr. Forman's resignation was accepted to become effective October 15, 1958, and the following statement adopted:**

"It is the belief of The Council that officials and employees are obligated to refrain from advocating in public statements on public questions, policies that are at variance with the official views of the organization. If one feels that he must pursue an opposite course, he should divorce himself from his official position.

"The Council's action is not in any sense of the word an attempt to censure Dr. Forman because his views on fluoridation differ from those expressed in the official policy of the Ohio State Medical Association.

"The Council defends the right of any person to think and believe as he pleases. Also, it defends the right of an individual **who is not an official or employee** of this Association to make public statements on any subject, even though such statements may be at variance with the Association's official position.

"The Council desires to express to Dr. Forman, on behalf of the Ohio State Medical Association, sincere thanks for his long and competent services as Editor of *The Ohio State Medical Journal.* The high standing which *The Journal* has attained is tangible evidence of the outstanding job which he has done for the membership of the Association."

Those who voted in the negative on the motion to accept Dr. Forman's resignation were: Doctors Dooley, Gustafson, Monger and Pease.

A motion to make the vote unanimous was then voted on. Those voting in the negative were: Doctors Dooley and Pease.

By official action, The Council then authorized the President to appoint a committee to interview prospects for the position of editor of *The Journal* and to report back to Council. Dr. Woodhouse named Dr. Mayfield, Dr. Martin and himself.

Belmont County Amendments

Following the executive session, The Council considered certain amendments which are to be voted upon by the Belmont County Medical Society. On the advice of Mr. Stichter and the Executive Secretary, The Council tentatively approved such amendments. It instructed the Executive Secretary to advise the Belmont County Medical Society that The Council will officially approve such amendments after their adoption by the Belmont County Medical Society.

Mahoning County Amendments

Consideration was given to lengthy amendments adopted by the Mahoning County Medical Society. These had been reviewed by Mr. Stichter, legal counsel, and the Executive Secretary as well as Dr. Gustafson, Councilor of the Sixth District. It was pointed out by them that there appeared to be a large number of questionable items in the amendments and it was their recommendation that The Council not act on all of the amendments at this meeting.

By official action, The Council **approved** amendments adopted by the Mahoning County Medical Society to existing Article 4 of the present Constitution of the society and amendments to existing Chapter 4 of the present By-Laws of the society. Such action was taken so the society could use the new provisions in electing officers, councilors and delegates for 1959.

By official action, **action was delayed** on the rest of the amendments submitted by the Mahoning County Medical Society and Mr. Stichter was instructed to prepare a memorandum of recommendations to be submitted to the Mahoning County Medical Society for its consideration.

Revised Constitutions and By-Laws Approved

The Council, by official action, then **approved** revised constitutions and by-laws submitted by the Pickaway County Medical Society, having been

adopted by that society on August 1, 1958, and the Huron County Medical Society, having been adopted by that society on March 12, 1958.

1959 Conference of County Society Officers and Committeemen

The Council selected the date Sunday, February 22, 1959 for the annual conference of county society presidents, secretaries and committeemen at the Deshler Hilton Hotel, Columbus. It instructed the Executive Secretary to extend an invitation to Dr. Julien P. Price, Florence, South Carolina, vice chairman of the Board of Trustees of the AMA to be a luncheon guest speaker at the February 22 meeting.

1959 Annual Meeting

The Council then, by official action, **approved** the plans drafted by the Committee on Scientific Work for the 1959 Annual Meeting in Columbus, April 21-24, inclusive. (See Pages 1465-1466 for schedule of events.)

By official action, The Council **selected Cincinnati** for the 1963 Annual Meeting the week of April 21.

There was a discussion of the honorarium paid to out-of-state guest speakers on the annual meeting program. By official action, The Council **authorized** the payment of $100.00 honorarium, in addition to expenses, starting with the 1959 Annual Meeting.

New OMI Contract

The Council then received a lengthy report from Dr. R. Dean Dooley, Dayton, Councilor of the Second District and chairman of the executive committee of Ohio Medical Indemnity, Inc., regarding a new and more liberal contract which has been developed by the Board of Directors of OMI and which will be placed on sale in the near future. After a general discussion by Dr. Dooley, Mr. Coghlan, executive vice-president of OMI, and individual members of The Council, The Council accepted the report by Dr. Dooley and officially commended the Board of Directors of OMI for having developed the new and more liberal contract. **(See pages 1478-1482 for detailed story.)**

Assignment Forms

A communication from a physician, advocating that Ohio Medical Indemnity pay physicians direct or attach an assignment blank to the report form filed by a contract holder, was discussed by The Council. Reference was made to the official action of the House of Delegates of the Ohio State Medical Association on this question at the 1956 Annual Meeting. Such action opposed payment of physicians direct and opposed the attachment of the blank routinely to report forms, but did approve payment by OMI jointly to a subscriber and a physician in cases where a properly executed assignment form is attached to the claim form filed by such subscriber. It was the opinion of The Council that The Council would have no authority to take any action contrary to the action taken by the House of Delegates in 1956.

Report of Cancer Committee

The Council then received a report from the Committee on Cancer.

In the report the committee pointed out that it would be highly desirable, both from an ethical and legal standpoint, if some legislation could be enacted to make either cancer alone or cancer and other non-communicable diseases reportable to the Ohio Department of Health so there would be no ethical or legal problem involved when physicians make such reports either to a cancer registry or to other agencies specified by law or regulation. Specifically, the committee **recommended** that The Council give consideration to sponsoring legislation along these lines.

After a lengthy discussion, The Council felt that it should have additional information on this matter before acting. Therefore, by official action, The Council **postponed action** on this recommendation so that additional information could be assembled for review by The Council.

Report of Committee on School Health

A report for the Committee on School Health was given by Mr. Page due to the absence of Dr. Thomas E. Shaffer, Columbus, chairman of that committee, because of the death of his father. The Council, by official action, expressed sympathy to Dr. Shaffer and requested the Executive Secretary to convey this message to him.

Mr. Page reported on the Fifth Ohio Conference on Physicians and Schools, held April 29, 30, and May 1, at Lake Hope, and on behalf of the State Planning Committee for Health Education thanked The Council for continued financial support of the Conference by the Ohio State Medical Association. He announced that six other associations and agencies assisted in making the 1958 Conference possible.

Mr. Page announced that the Committee on School Health will sponsor an exhibit at the annual Ohio Congress of Parents and Teachers in Cincinnati, October 6, 7 and 8.

Mr. Page also said that he would appear before the State Board of Control and the District Boards of the Ohio High School Athletic Association to discuss with them ways in which the Ohio State

Medical Association could promote and assist programs on athletic injuries, sponsored in cooperation with county medical societies.

He announced that assistance had been provided to the Health Teacher Training Sessions at Kent State University and Ohio State University during the summer. The report was **accepted and approved** by The Council.

Report of Committee on Poison Control

Mr. Page presented a report on behalf of the Committee on Poison Control and discussed the committee's report verbally.

By official action, The Council **approved** all parts of the report with the exception of a suggestion that the OSMA support legislation on uniform labeling. This part of the report was held over for future consideration in view of the fact that the committee is now holding conferences with other groups on this subject.

Report of Judicial and Hospital Relations Committees

Dr. Orr presented a report on behalf of the Committee on Hospital Relations and the Committee on Judicial and Professional Relations, based on a joint conference on August 10 with members of the professional relations committee of the Ohio Hospital Association.

The opinions expressed by the two OSMA committees in their joint report, reading in part as follows, **were approved** by The Council by official action: (1) Questions presented by the hospital association committee can be adjudicated through application of the "Joint Statement of Basic Principles for Guidance of Ohio Physicians and Ohio Hospitals" and the recently-adopted statement of The Council of the Ohio State Medical Association entitled, "Statement Regarding Unauthorized Practice of Medicine by Partnerships, Associations, Institutions, Corporations, Unlicensed Persons and the Ethical Status of Physicians Involved." Both statements are excellent guides to local arrangements which may be made without violation of the law prohibiting the corporate practice of medicine. Therefore, legislation is not necessary.

(2) The committees believe if amendments to the Medical Practice Act with respect to internships, licensing of foreign graduates, control of unlicensed and irregulars, etc., suggested by the hospital association, should become necessary, these matters should be discussed with representatives of the State Medical Board and other interested parties before any definite plans are made for proposed amendments to the Medical Practice Act. It was the sense of the committees that the need for amendments to the act as suggested by the hospital association committee has not been shown.

(3) It is the belief of the committees that an educational program among members of the Association should be carried on with respect to the recently-adopted Statement of Policy on Corporate Practice.

The Council also adopted a motion commending the two committees for their excellent work during the past year, especially with regard to the drafting of the official statement of policy on the unauthorized practice of medicine by corporations, et al., which was officially adopted by The Council on June 8, 1958.

Report of Committee on Public Relations and Economics

Dr. Frederick P. Osgood, Toledo, Chairman, submitted a report on a meeting of the Committee on Public Relations and Economics held on August 3. He and Mr. Saville discussed the report verbally.

Selection of Board of Health

Part 1 of the report dealt with action on Resolution No. 16 at the 1958 Annual Meeting, calling for a study of possible legislation to change the method of selection of members of district boards of health. The committee has been requested by The Council to make such a study. Reference was made to a conference with representatives of the Butler County Medical Society which had sponsored the resolution. Also, reference was made to studies which had been made in recent years to this subject. Dr. Osgood reported that the committee by unanimous vote had requested the Butler County Medical Society to present to the committee for future consideration, concrete suggestions for changes in the law designed to accomplish the objectives of the resolution.

By official action The Council **approved** this portion of the report.

Medical Care of Migrant Workers

Dr. Osgood reported that his committee had met with representatives of the Wood County Medical Society with regard to Resolution No. 17 at the 1958 Annual Meeting, asking for a solution to the problem of paying physicians for medical services to migrant laborers and their dependents. He stated that it was the consensus of the committee that: (1) experience has proved that voluntary insurance, as a solution to this problem, has proved impractical elsewhere because of the shifting tenure of the migrant worker's employment, difficulty of enrollment, and apathy on the part of the workers and employers; (2) the require-

ment that one particular type of employer, namely, employer of migratory workers, be compelled by law to carry health insurance on these workers would be discriminatory and contrary to the Association's policy in opposition to compulsory health insurance.

Dr. Osgood advised The Council that the committee unanimously voted to ask the Wood County Medical Society to formally request the county commissioners and the county welfare department to assume responsibility for the medical and hospital care of migrant laborers who are unable to pay for such care themselves, and further, that the Wood County Medical Society advise the committee of the reaction to such request.

He reported further that the committee also instructed the State Headquarters staff to initiate discussions with representatives of the Governor's Committee on Migrant Labor, the Ohio Department of Public Welfare, and any other groups which may be concerned in meeting this problem.

By official action The Council **approved** this portion of the report.

Simplified Insurance Forms

His committee reviewed the reaction of the Health Insurance Council to the proposed simplified insurance form for Ohio, which the committee tentatively approved at its meeting October 6, 1957, and subsequently transmitted to the Health Insurance Council for comment, Dr. Osgood reported.

He said the committee approved several changes in the proposed form in order to meet some of the objections raised by the Health Insurance Council.

By unanimous action, Dr. Osgood stated his committee recommended to The Council that arrangements be made to make a statewide simplified insurance form, drafted by the committee, available to members to be used by them if they wish in lieu of other forms which they consider too complicated.

In making this recommendation, the committee expressed the hope that local county medical societies which are now using their own insurance forms will adopt the OSMA-approved form and that it will have general usage throughout the state.

It was also brought out in the committee discussion, Dr. Osgood said, that while there is no guarantee that all insurance companies will accept the OSMA-approved claim form in all cases, it is the hope of the committee that this simplified form will eventually be widely accepted by most insurance companies.

The Council by official action **approved this part of the report and the insurance form referred to.** (Information about the new blank will be published in a later issue of *The Journal* after details have been worked out.)

Laboratories Survey

The final portion of the report of the Committee on Public Relations and Economics related to the report of a Subcommittee on Laboratory Services which had made a survey of hospital and clinical laboratories of the state and the recommendations of the subcommittee.

Dr. Osgood reported that the main committee had approved the report of the subcommittee, with the recommendation that if The Council authorizes the appointment of a Committee on Laboratory Medicine, as recommended, that this committee also be requested to continue the study of methods for the improvement of laboratory services in order to, as fully as possible, accomplish the intent of Resolution E concerning the matter of establishing qualifications and standards for diagnostic laboratories, passed at the 1957 session of the House of Delegates.

The Council **officially approved** this part of the report. **(See page 1493 for report and recommendations of Subcommittee on Laboratories.)**

Then, by official action, The Council **approved** the report and recommendations of the Committee on Public Relations and Economics as a whole and commended the committee on a fine report and constructive recommendations.

By separate action, The Council also **adopted** a motion commending the special laboratory committee, which had been headed by Dr. Horace B. Davidson, Columbus.

Report of Committee on Rural Health

The report of the Committee on Rural Health was presented by Dr. Robert E. Reiheld, Orrville, chairman of the committee. It was discussed verbally by him and Mr. Edgar, secretary of the committee. Dr. Reiheld reported that Glenn D. Hisrich, Stone Creek, O., Route 1, had been awarded the 1958 OSMA Rural Medical Scholarship, and informed the Council of the status of the nine previous winners.

He reported that the 1959 lectures to medical students at the three medical schools in Ohio all would be one-day programs since a test of this plan last February showed attendance considerably increased over the once-a-week lectures. He said the committee's second annual preceptorship program enabled 17 University of Cincinnati medical seniors spending two weeks with rural or small

(Continued on Page 1474)

The Achievements of Aristocort

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1, 2, 3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]...6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

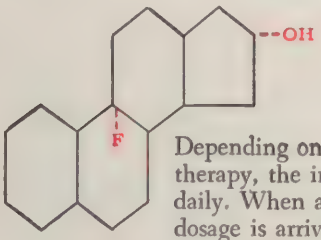
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4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
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11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

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...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

(Continued from Page 1471)

town general practitioners, and efforts are being made to include Ohio State University and Western Reserve University in the program.

Nearly 80,000 4-H Personal Health Records have been distributed to 4-H boys and girls in the past 18 months, and county 4-H health improvement contest winners have been awarded subscriptions to *Today's Health*, Dr. Reiheld stated. The boy statewide contest winner will be given $75 to aid in his expenses in attending the National 4-H Club Congress in Chicago next December.

Council voted **to accept** the report and to commend the committee for its activities.

Report of Committee on Traffic Safety

A brief report was submitted by the Executive Secretary on behalf of the Traffic Safety Committee. It was pointed out that the committee has been cooperating with the Department of Highway Safety and the Cornell Crash Injury Research Program. Mr. Nelson also pointed out that a large majority of the county medical societies have appointed Traffic Safety Committees as requested by the OSMA committee. He pointed out that the committee will meet again in the near future to devise a program of activities on a short-term and long-term basis.

The report was **officially approved.**

Report of Maternal Health Committee

Dr. Ruppersberg, Chairman of the Committee on Maternal Health, presented on behalf of his Committee, the Ohio Maternal Mortality Study covering the year 1955.

The Council **approved the report,** with special commendation to the Committee and to the physicians who cooperated in securing information for the study. **(See pages 1458-1459 for text of report.)**

Perinatal Mortality Studies in Ohio Approved

A committee representing the Ohio Chapter, American Academy of Pediatrics, appeared before The Council to discuss a proposal that perinatal mortality studies be inaugurated in all Ohio hospitals by the physicians of such hospitals participating in obstetrical and newborn services. Those presenting the subject to The Council were: Dr. J. Victor Greenebaum, Dr. Carl J. Ochs and Dr. Arthur King, Cincinnati; Dr. Edward V. Turner and Dr. James Williams, Columbus; and Dr. Robert Morrison, Zanesville. They discussed several pilot studies which have been made throughout the state and suggested that The Council give serious consideration to approving the idea of asking all hospitals to inaugurate such studies.

By official action, The Council **approved** the project which is to be sponsored by the Ohio Chapter, American Academy of Pediatrics, in cooperation with other organizations, and commended the Academy for this program.

Medicare Program

Mr. Nelson presented a report on the present status of the Medicare Program, based on a meeting held in Washington on August 8 which he attended on behalf of the Association and on official directives received since that meeting with respect to a severe cutback in the program. He referred to a detailed article which will appear in the October 1 issue of *The Ohio State Medical Journal* on this subject.

Fall Pre-Election Conferences

Mr. Saville reported on plans which have been completed for the Fall pre-election conferences in the 11 Councilor Districts during the week of September 15.

November 4 Election

The Council discussed thoroughly the two issues which will be on the ballot at the November 4 election proposing amendments to the Ohio Constitution, namely, the so-called "Right To Work" proposal and the county government charter proposal. It was the opinion of The Council that no official action should be taken on these proposals inasmuch as neither involves a medical or health question and that it would be up to each individual physician to decide for himself as a voter and citizen as to whether he favors either or both proposals.

Request from Medical Board

A communication from Dr. H. M. Platter, Secretary of the State Medical Board, was read and discussed. The letter stated that the State Medical Board will ask the next General Assembly to adopt an amendment to the Ohio Medical Practice Act increasing the fee for examination from $25.00 to $50.00 and the fee for endorsement from $50.00 to $100.00. The letter pointed out that the income from the Board from all sources amounts to approximately $43,000 annually, which is less than the expenditures necessary for the Board. It is the opinion of the Medical Board that more adequate appropriations for the Board can be secured from the Legislature providing there is an increase in the revenue paid into the general fund by the Board. The communication asked the active support of the Ohio State Medical Association. By official action, The Council voted **to actively support** a change in the

Medical Practice Act as outlined in the communication from the Board.

OSMA Group Life Insurance Program

A report from Turner and Shepard, Inc., Columbus, regarding the OSMA group life insurance program was presented and considered by The Council. The report pointed out that 940 physicians and 294 employees of physicians, a total of 1,234 were enrolled for the basic coverage as of September 9. It was pointed out in the report that after a September 18 deadline for state-wide annual enrollment, enrollment would be open for a period of 60 days in certain Councilor Districts. Assistance of the Councilors on the re-enrollment programs by districts was requested. The report stated that the underwriting company, Union Central of Cincinnati, has agreed that all applicants in a Councilor District will be issued the basic insurance without evidence of insurability if 50 per cent of the members in the district enroll, including those already enrolled.

American Medical Education Foundation

Plans for the 1958 campaign in behalf of the American Medical Education Foundation were presented by Dr. Merrill D. Prugh, chairman of the Ohio AMEF committee, and by Mr. Saville.

Dr. Prugh discussed the vital importance of additional private support of medical schools. He reminded members of The Council that as members of the Ohio AMEF Committee it is their responsibility to stimulate interest in AMEF in their respective councilor districts.

Mr. Saville reported that contributions from Ohio physicians to AMEF and directly to the Alumni Funds of medical schools reached an all-time high in 1957. Donations to AMEF amounted to $33,141.87 from 717 donors. A total of $132,566.56 was contributed by 3,646 Ohio physicians directly to medical schools, making a grand total of $165,708.43 from 4,363 contributors. He pointed out that the AMEF total included $10,682.34 raised through various projects by the Woman's Auxiliaries, for which they received national recognition.

The Council **accepted the report** and thanked Dr. Prugh for his interest in this important activity.

Workmen's Compensation Fee Schedule

The Executive Secretary presented a report on action by the Bureau of Workmen's Compensation with respect to certain increases in the Medical and Surgical Fee Schedule effective October 1. A memorandum on the changes in the fee schedule was presented to The Council for its information. It was pointed out that the Bureau did not approve recommendations of the OSMA in their entirety but did accept most of the recommendations in part. Mr. Nelson stated that an article on this matter has been prepared and will be published in the October issue of *The Ohio State Medical Journal.*

By official action, The Council **expressed its appreciation** to the Bureau of Workmen's Compensation for having accepted part of the recommendations of the Association, even though some of the increased fees which become effective October 1 do not appear to be compatible with present economic conditions.

Request from Internists

A request from the Ohio Society of Internal Medicine that a provision similar to certain sections of the Medicare Fee Schedule covering services of internists be included in the fee schedule covering the Veterans Administration Hometown Care Program in Ohio, was considered. By official action, The Council **decided** to suggest to the Veterans Administration that it include special fees for services of internists in the Ohio V. A. Fee Schedule to be effective at the beginning of the next fiscal year, namely, July 1, 1959.

Iowa Public Relations Plaque

A request from an advertising company in Des Moines, Iowa, that the Ohio State Medical Association sponsor the sale of a public relations plaque similar to the one used by the Iowa State Medical Society, was discussed. By official action, The Council felt that this project should not be undertaken at this time.

Report on AMA House of Delegates

Dr. Charles L. Hudson, Cleveland, gave a detailed report on sessions of the House of Delegates held in connection with the San Francisco meeting of the AMA in June, 1958. His report was supplemented by comments from other Ohio delegates to the AMA present at this meeting.

Control of Staphylococcal Disease

A communication from the Ohio Department of Health, asking the Association to send an official representative to a regional conference on control of staphylococcal disease in hospitals, in Chicago on October 10, was discussed. By offcial action, The Council **approved** the sending of an official representative to the conference.

Plaque for Out-Going Councilors

During that period of the meeting devoted to reports by Councilors a motion was adopted authorizing the preparation of a certificate or plaque

which would be presented by the Association to all Councilors terminating office under the constitutional provision placing a three-term limit on Councilors, such recognition to start with the 1959 Annual Meeting.

The Council, having completed its business, then adopted by a rising vote a motion to adjourn in honor of the following former officers and Councilors who have died during the past year: Dr. Clyde L. Cummer, Cleveland, Dr. Harry V. Paryzek, Cleveland, and Dr. Ralph L. Rutledge, Alliance, former presidents; and Dr. James R. Jarvis, Van Wert, Dr. Guy E. Noble, St. Marys, and Dr. Emmett B. Shanley, New Philadelphia, former Councilors.

Attest: CHARLES S. NELSON,
Executive Secretary.

Cincinnati Fund To Provide Appliances For the Medically Indigent

Establishment of a special fund to provide the medically indigent with prosthetic appliances and special medicines has been announced by Dr. Bernard A. Schwartz, Cincinnati, president of the Max, Martha and Alfred M. Stern Fund for Special Medicines and Appliances.

Initial contributions aggregate a sum of $100,000.00 with $25,000.00 immediately available for use by the Fund. Mr. Murray Seasongood, brother of the late Martha Seasongood Stern, and Mrs. Seasongood made the fund possible.

Dr. J. Robert Hudson, incoming president of the Academy of Medicine of Cincinnati, will be the official representative of the Academy on the executive committee of the fund. Dr. Schwartz is chairman of the executive committee of the Stern Fund. Other members are Murray Seasongood, Jeanette P. Long, Agnes Seasongood, Mary H. Beckjord, Dr. Carl A. Wilzbach and Dr. Hudson.

General Physicians Promote Radiology Course Series

The Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine is presenting a series of courses on radiology. The programs are held on Tuesday mornings from 9:00 to 11:00 a. m. under direction of Dr. Benjamin Felson, professor and director of the Department of Radiology. Secretary of the program committee for the SOSGP is Dr. Gaston B. Hannah. The seminar began on October 14 and will run through January 27.

Hospital Disaster Planning References Listed

Following are excerpts from a report of the Hospital Disaster Planning Committee of the Ohio Hospital Association:

In studying the list of hospitals which do not have disaster plans, the committee has noted that most are in the 100 beds or less group. Many of these are in one-hospital communities where the obligation is particularly heavy in time of disaster. The following references have been selected to be of assistance to the hospitals of the group:

Experiences in the Handling of a Disaster in a Small Hospital, by Paul E. Campbell, M. D., and Robert M. Jones, *Hospital Management,* June 1957—Vol. 83.

How a Small Hospital Has Prepared, *The Canadian Hospital,* March 1955—Volume 32.

85 Bed Hospital is Equal to 400 Victims, by Ralph M. Haas, *The Modern Hospital,* June 1958—Vol. 90.

Role of the Medical Staff in Emergency Service, Mass Casualty Handling, by James H. Irwin, *Hospitals, J. A. H. A.,* July 1957, p. 54 Vol. 31.

Readings in Disaster Planning for Hospitals, *A. H. A.,* 1956.

Preparation for Local Disaster, *Manual of Disaster Planning for the Hospitals of Ohio.*

Principles of Disaster Planning for Hospitals, 1956.

If copies of these periodicals are not accessible directly, they may be obtained from the American Hospital Association Library, 18 East Division Street, Chicago 10, Illinois.

The Ohio Hospital Association also maintains a series of portfolios containing a large number of disaster plans of other Ohio Hospitals of all sizes. The purpose of these portfolios is to provide examples which will assist the individual administrators in creating plans that will meet the particular needs of their hospital.

Obstetrics and Gynecology

The Part I Examinations of the American Board of Obstetrics and Gynecology, are to be held in various parts of the United States and Canada, on Friday, January 16, 1959, at 2:00 p. m. Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office, Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Comments by investigators on

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Robins



—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

New Ohio Medical Indemnity Contract . . .

More Liberal Schedules of Indemnities and New Coverages Offered; Big Job To Exchange This for Old Contracts Emphasized by OMI Officials

OHIO MEDICAL INDEMNITY, Inc., the Ohio Blue Shield Plan, is making available on November 1, 1958, a new and more liberal contract.

The increasing number of expressions of dissatisfaction from subscribers and physicians with regard to the indemnities which were paid by Ohio Medical, particularly involving the Standard Contract, prompted the Board of Directors to authorize a state-wide survey of current charges for medical services.

This new contract, developed as a result of the survey, not only approaches the current level of physicians' charges, but also includes new coverages not heretofore offered by Ohio Medical.

Big Sales Job Ahead

An outline of the new contract was presented to The Council of the Ohio State Medical Association at its September, 1958, meeting by Dr. R. D. Dooley, chairman of the OMI Executive Committee.

Dr. Dooley pointed out that this more comprehensive coverage **will not immediately replace existing contracts, as it will take some time to effect this exchange of contracts.** Nevertheless, it was felt that Ohio Medical should have this contract available **now** for those groups that wish to purchase a contract providing indemnity payments more closely related to current physicians' charges, he told The Council.

In a statement to *The Journal* regarding the new contract, Dr. H. M. Clodfelter, president of Ohio Medical Indemnity, emphasized how important it will be for Ohio physicians to actively promote the purchase of the more liberal contract by all subscriber groups at the earliest possible time.

Hope To Cover All Eventually

"At present Ohio Medical has about 748,000 Standard Contracts and about 160,000 Preferred Contracts outstanding," Dr. Clodfelter said. "Obviously, the hope of OMI officials is that all these contracts will be converted eventually to the new contract which has just been adopted. Also, obviously, it will be a big job to convince all of the many groups of subscribers that they should have the better coverage offered under the new contract. Doctors can help a lot on this, by talking up the new contract among their Blue Shield patients and recommending to them that their group convert to the new contract at the earliest possible time."

Speakers For County Medical Societies

Members of the Board of Directors of Ohio Medical have expressed a willingness to attend meetings of County Medical Societies and hospital staff meetings to discuss the new contract and answer questions concerning it. Requests for OMI speakers should be sent to Mr. Charles H. Coghlan, executive vice-president, Ohio Medical Indemnity, 3770 N. High Street, Columbus.

Commenting on the necessity for explanation of the new contract to physicians, Dr. George A. Woodhouse, President of the Ohio State Medical Association, stated he hoped that all County Medical Societies will take advantage of this offer of OMI directors.

"It would be fine if each County Medical Society would arrange to devote a meeting in the near future to a discussion of this new OMI contract and OMI activities in general," Dr. Woodhouse said. "Members of the OMI board are familiar with the contract and therefore quite competent to explain it in detail. As physicians become more familiar with the contract, they will become enthusiastic about promoting it, I am sure. We don't expect doctors to be OMI salesmen but we do hope that they will be OMI boosters which is only accomplishing the same thing in a different way."

Mr. Coghlan has announced that a brochure giving details about the new contract will be ready soon for distribution to the medical profession.

Surgical Anesthesia Section of Contract

The Surgical-Anesthesia Section of the contract will provide a higher schedule of indemnities for surgical procedures with a maximum payment of $450. This new surgical schedule is in line with present average charges in Ohio for surgical services.

The anesthesia coverage has been revised and will provide payments as high as $75 for some of the major surgical procedures.

Samples of New Contract

Here are some samples and examples of the

indemnities of the Surgical-Anesthesia Section of the new contract:

*The asterisk indicates that local anesthesia is customarily administered and that no indemnity is payable. If general anesthesia is required and administered in such instances, the amount of the indemnity, if any, will be determined by Ohio Medical Indemnity.

	Surgical Indemnity	Anesthesia Indemnity
Integumentary System		
Skin and Subcutaneous Areolar Tissue		
Incision and drainage of infected steatoma, furuncle or small subcutaneous abscess	$ 15.00	*
Local excision of small benign neoplastic lesion	25.00	*
Excision of pilonidal cyst or sinus	125.00	$ 25.00
Burns or Skin Grafts	Amount of indemnity to be determined by Ohio Medical	
Suturing of wound or wounds within twenty-four (24) hours after accident	Amount of idemnity to be determined by Ohio Medical	
Breast		
Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple (including any other partial mastectomy):		
unilateral	75.00	25.00
bilateral	100.00	25.00
Complete mastectomy, simple:		
unilateral	125.00	25.00
bilateral	175.00	30.00
Radical mastectomy	275.00	60.00
Musculoskeletal System		
Fractures		
Clavicle: simple	50.00	*
compound or open operation	100.00	25.00
Scapula: simple	50.00	*
compound or open operation	100.00	25.00
Rib: simple strapping	25.00	*
Humerus: simple	100.00	*
compound or open operation	200.00	35.00
Radius, head or shaft: simple	75.00	*
compound or open operation	150.00	30.00
Radius, distal end Colles'; simple	75.00	*
compound or open operation	150.00	30.00
Ulna, shaft: simple	75.00	*
compound or open operation	150.00	30.00
Radius and Ulna, shafts: simple	100.00	25.00
compound or open operation	150.00	30.00
Phalanx: simple	25.00	*
compound or open operation	50.00	20.00
Femur: simple	250.00	30.00
compound or open operation	350.00	50.00
Tibia, shaft: simple	100.00	20.00
compound or open operation	150.00	30.00
Fibula, shaft: simple	75.00	*
compound or open operation	100.00	25.00
Tibia and Fibula, shaft: simple	125.00	30.00
compound or open operation	200.00	40.00
Dislocations		
Temporomandibular, closed reduction	25.00	10.00
Clavicle: closed reduction	75.00	25.00
open reduction	250.00	45.00
Shoulder (humerus), closed reduction	75.00	25.00
Knee (tibia), closed reduction	100.00	25.00
Ankle, closed reduction	75.00	25.00
Amputations		
Disarticulation of shoulder	350.00	60.00
Arm through humerus	150.00	30.00
Forearm, through radius and ulna	150.00	30.00
Disarticulation of wrist	150.00	30.00
Hand through metacarpal bones	150.00	30.00
Finger, any joint or phalanx	50.00	20.00
Thigh, through femur, including supracondylar	250.00	45.00
Leg, through tibia and fibula	200.00	40.00
Toe, any joint or phalanx	50.00	20.00
Respiratory System		
Septectomy: submucous resection	150.00	30.00
Maxillary sinusotomy, simple; antrum window operation	50.00	*
Maxillary sinusotomy, radical	150.00	30.00
Ethmoidectomy, intranasal	100.00	*
Bronchosocopy:		
diagnostic, with or without biopsy	75.00	10.00
with removal of foreign body	125.00	20.00
Total Pneumonectomy	450.00	75.00
Lobectomy, total or subtotal	450.00	75.00
Cardiovascular System		
Ligation and division of saphenous vein and branches at saphenofemoral junction, with or without retrograde injection,		
unilateral	100.00	35.00
bilateral	150.00	35.00
Complete radical removal of entire great saphenous system,		
unilateral	175.00	45.00
bilateral	225.00	45.00
Cardiac catheterization	100.00	*
Valvulotomy	450.00	75.00
Digestive System		
Tonsillectomy, with or without adenoidectomy	65.00	20.00
Esophagoscopy:		
diagnostic, with or without biopsy	75.00	10.00
operative including removal of foreign body	150.00	20.00
Total gastrectomy	400.00	75.00
Pyloroplasty	200.00	40.00
Gastrojejunostomy or gastroduodenostomy	250.00	40.00
Enterectomy, resection of small intestine	250.00	45.00
Colectomy: resection of large intestine, all or part, one or more stages	300.00	50.00
Excision of Meckel's Diverticulum	150.00	30.00
Appendectomy	150.00	30.00
Fistulotomy or fistulectomy	125.00	25.00
Incision and drainage of ischiorectal abscess	50.00	20.00
Fissurectomy, with or without sphincterotomy	50.00	20.00
Hemorrhoidectomy:		
Internal, or internal and external	125.00	25.00
Internal with fissure	140.00	25.00
Internal with fistula	160.00	25.00
Cholecystectomy	250.00	40.00
Exploratory laparotomy	150.00	25.00
Herniotomy, inguinal or femoral:		
unilateral	150.00	30.00
bilateral	200.00	40.00

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	Surgical Indemnity	Anesthesia Indemnity
Urinary System		
Pyelolithotomy	300.00	50.00
Nephrectomy	300.00	60.00
Nephropexy: fixation or suspension of movable kidney	200.00	40.00
Cystoscopy:		
diagnostic, initial	50.00	20.00
subsequent (maximum of four)	20.00	10.00
Cystoscopy:		
with stone removal and ureteral dilation or with fulguration of bladder tumor, initial	100.00	25.00
subsequent (maximum of four)	20.00	10.00
Ureterolithotomy	225.00	40.00
Male Genital System		
Circumcision: 31 days to 12 years of age	15.00	*
age 12 or over	60.00	25.00
Orchiectomy	100.00	25.00
Excision of hydrocele	100.00	20.00
Prostatectomy, one or more stages, complete or partial	300.00	35.00
Female Genital System		
Excision or cautery destruction of Bartholin's gland or cyst	75.00	25.00
Repair of cystocele	125.00	30.00
Repair of rectocele	125.00	30.00
Repair of cystocele and rectocele	175.00	30.00
Salpingectomy	150.00	30.00
Salpingo-oophorectomy	150.00	30.00
Oophorectomy	150.00	30.00
Hysterectomy (with or without dilation and curettage and surgery on tubes, ovaries, ligaments, etc.):		
Panhysterectomy; total hysterectomy (corpus and cervix); Supracervical hysterectomy; sub-total hysterectomy	250.00	40.00
Radical hysterectomy for cancer (Wertheim)	350.00	65.00
Vaginal hysterectomy, with or without pelvic floor repair	250.00	40.00
Amputation of cervix	125.00	30.00
Dilation and curettage of uterus	65.00	20.00
Hysteropexy (with or without surgery on tubes, ovaries, etc.)	150.00	30.00
Endocrine System		
Thyroidectomy, complete or partial, total or subtotal	250.00	45.00
Hemithyroidectomy: lobectomy	250.00	45.00
Excision of thyroglossal duct, cyst or sinus	200.00	35.00
Nervous System		
Trephination (or burr holes) exploratory	150.00	40.00
Laminectomy	400.00	75.00
Excision of brain cyst, neoplasm or abcess	450.00	75.00
Sympathectomy: cervical or lumbar	250.00	50.00
Drainage of subdural hematoma	400.00	75.00
Eye		
Enucleation of eyeball (bulb or globe), with or without implantation of prosthesis	200.00	40.00
Probing of lacrimonasal duct	25.00	20.00
Extraction of lens, intracapsular or extracapsular	250.00	*
Myotomy, tenotomy, recession, resection, advancement or shortening of ocular muscles for strabismus, one or more stages:		
unilateral	175.00	30.00
bilateral	200.00	30.00
Excision of chalazion	25.00	*
Ear		
Myringotomy	15.00	*
Fenestration of semicircular canals	400.00	75.00
Mobilization of stapes	225.00	40.00
Obstetrics		
Obstetrical delivery	50.00	None
Caesarean section	200.00	30.00
Caesarean section and hysterectomy (Porro)	250.00	40.00
Removal of extra-uterine embryo (ectopic pregnancy) by laparotomy	200.00	30.00
Miscarriage or abortion, before period of viability (no surgery)	25.00	*
Miscarriage or abortion, including dilation and curettage	65.00	20.00
Dilation and curettage of uterus for postpartum bleeding	65.00	20.00

In-Hospital Medical Services Section

The contracts of Ohio Medical Indemnity, Inc., currently provide for a per diem method of paying for in-hospital medical services. The survey mentioned previously revealed that this per diem method resulted in the overpayment to some subscribers, particularly the long-stay cases, and the underpayment to other subscribers, most often those who were acutely ill and received an extraordinary amount of medical care in a relatively short stay.

The new contract will continue to provide per diem payments of $10 for the first day; $5 for each of the next three days of each hospital confinement; $4 a day thereafter up to a total of 30 days.

Patients remaining in the hospital beyond 30 days are eligible under the new contract for 90 additional days' coverage at $4 a day depending on the illnesses involved. Patients hospitalized for geriatric, chronic, convalescence or nervous and mental conditions will not be paid for more than 30 days' coverage. In addition to the above per diem payments, the new contract will provide a supplemental indemnity for serious cases requiring an extraordinary amount of medical care during the first few days of hospitalization, such as acute heart conditions, diabetic coma, etc. The supplemental payments—for services beyond the first 30 days in hospital and for serious cases requiring extraordinary medical care during the first few days—were designed to meet the inconsistencies disclosed in the survey and will be deter-

mined by Ohio Medical Indemnity through its Medical Advisory Committee.

Radiotherapy

The indemnity payments under the Radiotherapy Section of the contract are as follows:

An indemnity of $10 per treatment will be provided for deep x-ray therapy with a limit of fifteen treatments per year. Skin neoplasms treated with x-ray will be paid at $5 per treatment, with a limit of six treatments per year.

The payment for radium application to skin neoplasms will be $20 per treatment with a maximum of three treatments per year. Payment for radium treatment to other than skin neoplasms will be $75 per treatment with a maximum of two treatments per year. An indemnity will also be provided for the use of isotopes in the treatment of neoplasms.

New Benefit Added

A new benefit has been added under this section of the contract, namely, the provision of an indemnity for the therapeutic use of I^{131}. No indemnity will be paid for I^{131} uptake studies for diagnostic purposes.

Limited Diagnostic X-Ray and Laboratory Examinations

Two entirely new coverages are included in the new contract. Since Ohio Medical subscribers invariably have a companion Blue Cross contract providing x-ray and laboratory benefits for hospitalized bed patients, the new benefits are designed to idemnify the subscriber towards the cost of some diagnostic x-ray and laboratory procedures performed in a physician's office or in the out-patient department of a hospital. **All diagnostic x-ray and laboratory procedures could not be covered for actuarial reasons.** Only those x-ray and laboratory procedures listed in the contract will be covered.

Following are the indemnities in the new contract for diagnostic x-ray and laboratory examinations:

Diagnostic X-Ray Examination Indemnities

Mylography	$ 20.00
Eye for foreign body	12.00
Eye for localization of foreign body	20.00
Bronchogram	20.00
Fistula examination with contrast	12.00
Cholangiography, post operative	16.00
An indemnity will be provided as shown for the following examinations with a maximum payment of $40.00 per patient per contract year.	
G. I. Tract—Complete (barium meal and barium enema), including gall bladder study	40.00
Esophagus, with contrast	12.00
Small bowel studies, with contrast	16.00
Upper gastro-intestinal tract, with contrast	20.00
Colon by barium enema	16.00
Colon by barium enema and double contrast	20.00
Gall bladder, cholecystography	16.00
An indemnity will be provided as shown for the following examinations with a maximum payment of $36.00 per patient per contract year.	
Pyelography—intravenous	20.00
Pyelography—retrograde	16.00
Cystography	12.00
Urethrocystography	12.00

X-Ray Examinations, Accidents Only

If two or more of the following diagnostic x-ray examinations are conducted successively on account of injuries sustained in one accident, the total amount payable therefor shall be limited to the amount specified in the Schedule of Diagnostic X-ray Examination Indemnities for that examination, which has the greatest indemnity, plus one-half of that diagnostic x-ray examination which has the next greatest indemnity, plus one-half of the amount specified for that diagnostic x-ray examination which has the third greatest indemnity, providing the service is rendered within forty-eight (48) hours of an accident. No payment shall be made for more than three such examinations.

Shoulder	$ 8.00
Arm	8.00
Elbow	8.00
Forearm, including one joint	8.00
Wrist	8.00
Hand	8.00
Fingers	4.00
Hip, single film	8.00
Hip, complete, multiple positions	16.00
Femur, including one joint	8.00
Knee	8.00
Leg, including one joint	8.00
Ankle	8.00
Foot	8.00
Toes	4.00
Spine, cervical	12.00
Spine, thoracic	12.00
Spine, lumbo-sacral	12.00
Spine, sacro-coccygeal	12.00
Spine, lumbo-sacral, including pelvis and hips	12.00
Facial bones	8.00
Nasal bones	8.00
Skull	12.00
Mandible	8.00
Ribs	8.00

Laboratory Examination Indemnities
($50.00 maximum per patient per year)

Blood	Schedule of Indemnity
Antistreptolysin Titer	$ 6.00
Blood Culture, definitive	6.00
Bone Marrow, collection and interpretation	12.00
Bone marrow, interpretation	8.00
Bromsulphalein	5.00
Congo red, complete test	8.00
CO_2 content, arterial blood	7.00
Cholesterol esters	8.00
Complement Fixation Tests for Viruses	8.00
Creatine tolerance	16.00
Electrophoresis pattern, protein	8.00
" " lipoprotein	8.00
" " hemoglobin	8.00

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	Schedule of Indemnity
Hemoglobin, sulfhemoglobin quan.	8.00
Iron Binding Globulin saturation, serum	8.00
Oxygen saturation, arterial blood	7.00
Insulin Tolerance Test	12.00
L-E Test (Dog or Human Marrow)	8.00
Lead, serum or urine	12.00
Oxygen content, arterial blood	7.00
Oxycorticoids	12.00
Protein-bound Iodine	12.00
Sugar (Glucose) Tolerance, per specimen	3.00
Rh, complete	8.00
Urea Clearance	8.00
Vitamin A	8.00
Volume	8.00
Feces	
Culture, definitive	8.00
Gastric or Duodenal (Aspiration included)	
Chemical, acid, Fractional (histamine)	8.00
Culture for TB, Animal inoculation	12.00
Spinal Fluid	
Collection	6.00
Chemical Tests, serology, microscopic (including cell count, colloidal gold or gum mastic)	16.00
Culture for Bacteria, plus acid fast	8.00
Animal inoculation for Bacteria	12.00
Urine	
Quantitative Functional (Addis)	10.00
Porphyrins, quantitative	8.00
Culture, definitive	6.00
plus acid-fast	8.00
Animal inoculation	12.00
17-Ketosteroids	10.00
11-Oxysteroids	10.00
Gonadotropins	12.00
Pregnandiol	10.00
Estrogen Assay	12.00
17-Hydroxycorticoids	14.00
Miscellaneous	
Howard Test	16.00
Insulin, Complement Fixation	8.00
Mercury, urine	8.00
Semen, complete analysis	8.00
Cytology	
Papanicolaou Smear, only for gastric including collection	12.00
Surgical Pathology	
Class A—Surface biopsies of uncomplicated character not requiring special stains and certain surgical specimens as appendix, gallbladder, etc.	6.00
Class B—Surgical specimens of more complicated character such as lymph nodes, tumors of soft tissues, needle biopsies, etc.	8.00

Limitation on Total Payments

The new contract contains a provision that the payment to a subscriber shall not exceed the total costs incurred for physicians' services, subject to the maximum amounts specified in the schedules of indemnities.

Enrollment in Ohio Medical now stands at 2,255,000 members, making it the fourth largest Blue Shield plan in the United States. Payments to subscribers are currently averaging $1,600,000 per month.

General Practitioners of Franklin County Offer Fall Seminar

The Franklin County Academy of General Practice is presenting its Fall Seminar in Columbus on Friday, November 21, at the New Veterans Memorial Building. This is the day before the Ohio-Michigan game.

The seminar is approved for 5½ hours credit for General Practice members. Attendance will be limited to 150 members. Tuition for AAGP members is $15; for non-members, $20.00. Preregistration should be sent to E. D. McCallister, M. D., 877 Mohawk St., Columbus 6, Ohio. For those who wish to leave early, the program will be over by 3:30. For those who wish to stay for the game, hotel reservations should be made with any of the Columbus leading hotels.

The program has been announced as follows:

8:30 a. m.—Registration.
9:00 —**Minor Surgery in the Office,** Dr. Warren Harding, Worthington.
9:30 —**Management of Eye Disorders,** Dr. Malcolm McCannel, Minneapolis, Minn.
10:15 —**Office Management of Acute and Chronic Ear Disorders,** Dr. Carl Roth, Columbus.
10:45 —Break.
11:00 —**Office Proctology,** Dr. Karl Zimmerman, Pittsburgh, Pa.
11:45 —Panel of Morning Speakers—Questions and Answers.
12:15 p. m.—Seafood Luncheon, Kit Carson, Columbus.
1:15 —**Office Anesthesia, Regional and Local,** Dr. Robert Smith, Circleville.
1:45 —Management of Injured Athlete on Playing Field, in Training Room and Office, Dr. Richard Patton, OSU Team Physician, Columbus.
2:25 —Break.
2:30 —**Office Management of Urologic Problems,** Dr. Hall Wiedemer, Mansfield.

Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in the Drake Hotel, Chicago, Illinois, April 30, May 1 and 2, 1959.

Interstate Program in Cleveland Will Include Many Ohio Physicians

The Interstate Postgraduate Medical Association is sponsoring the Interstate 43rd International Medical Assembly at the Cleveland Public Auditorium and the Statler-Hilton Hotel, Cleveland, November 10 - 13.

A number of Ohioans are on the program. Following are topics to be discussed by Ohio physicians:

"Recent Pharmacologic Advances Applicable to Obstetrics and Gynecology," Dr. Allan C. Barnes, chairman of the Department of Obstetrics and Gynecology, Western Reserve.

"Cancer of the Breast," Dr. George Crile, Jr., head of the Department of General Surgery, Cleveland Clinic.

"The Treatment of Respiratory Emergencies," Dr. Jay Jacoby, director of the Department of Anesthesiology, Ohio State University.

Panel on "Diseases of the Pancreas," Dr. Robert M. Zollinger, chairman of the Department of Surgery, Ohio State; Dr. Edwin H. Ellison, professor of surgery, Marquette University (formerly of OSU); Dr. Dan W. Elliott, assistant professor of surgery, OSU; Dr. Stanley O. Hoerr, chairman, Division of Surgery, Cleveland Clinic; Dr. William D. Holden, professor of surgery, Western Reserve.

"Surgical Treatment of Persistent Symptoms Following Cholecystectomy," Dr. Zollinger.

"Medical and Surgical Problems in Liver Disease," Dr. William A. Altemeier, chairman, Department of Surgery, University of Cincinnati; Dr. Richard W. Vilter, director, Department of Internal Medicine, University of Cincinnati.

"Athletic Injuries and What To Do with Them," Dr. Richard Patton, clinical assistant professor of surgery, Ohio State.

"The Tired Mother Syndrome," Dr. Leonard L. Oovshin, Division of Medicine, Cleveland Clinic.

"Special Considerations Regarding Fractures in Children," Dr. Charles H. Herndon, associate professor of orthopedic surgery, Western Reserve.

"The Use of Diuretics in the Treatment of Hypertension," Dr. Hariet P. Dustan, Cleveland Clinic.

In addition, a number of Ohio physicians will present exhibits during the meeting, and others will participate in teaching demonstrations.

In the United States the number of married couples was almost 39 million in 1957, an increase of 37 per cent over the 1940 figure of 28.5 million.—*Metropolitan Life.*

Do You Know? . . .

OSMA President-Elect Frank H. Mayfield extended the convocation address to the freshman class of The Ohio State University College of Medicine September 29.

* * *

Dr. Richard W. Vilter, director of the Department of Internal Medicine, University of Cincinnati College of Medicine, recently went to Geneva, Switzerland, to participate in the World Health Organization's first study session on anemias. He reported on his research on the relationship between anemias and nutritional deficiency.

* * *

Recent visiting professor in the University of Cincinnati College of Medicine was Dr. Richard Shuman, Washington, D. C., chief of the Section on Soft Tissue Tumors at the Armed Forces Institute of Pathology.

* * *

Professor Chauncey D. Leake, assistant dean of the OSU College of Medicine, Columbus, presided at recent sessions of the American Society for Pharmacology and Experimental Therapeutics held at the University of Michigan, Ann Arbor. He also held informal discussions on teaching pharmacology to non-medical students.

* * *

Dr. E. Perry McCullagh, Cleveland, is the new president of the Endocrine Society, having been installed at the organization's annual meeting in San Francisco. He is head of the Department of Endocrinology and Metabolism at Cleveland Clinic.

* * *

The eleventh Henry B. Frieberg Memorial Lecture was given on October 21 in the School of Nursing auditorium, Jewish Hospital and Medical Center, Cincinnati. Lecturer was Dr. Felix Wroblewski, New York City, who discussed the subject of "Biochemical Biopsy Via Body Fluids."

* * *

Robert L. Richards, assistant director of The Medical Society of the State of Pennsylvania, has resigned that position in order to become Executive Secretary of the American Society of Internal Medicine with headquarters in San Francisco, the resignation effective December 31.

* * *

At a special meeting of the House of Delegates of the Oklahoma State Medical Association held on September 21, the House of Delegates voted to not continue participation in the Department of Defense's program for medical care for dependents of military personnel.

Barbiturate Control Act . . .

Ohio Has Strict Law on Distribution and Use of Barbiturate; Here Are High Points of the Law Including Restrictions, Keeping of Records, etc.

OHIO has a strict law in regard to barbiturate and every physician in practice should be thoroughly familiar with its provisions. The law is intended to crack down on illict use of the drug and imposes only enough restrictions on physicians to make it unpopular for them to be careless in prescribing or administering.

A previous article in *The Journal* detailed provisions of the Ohio Narcotics Control Act. Refer to pages 1366-1372, October, 1958, issue.

Following are excerpts of the Barbiturate Control Act:

Definitions

Sec. 3719.23. As used in sections 3719.23 to 3719.29, inclusive, of the Revised Code:

(A) "Barbiturate" means the salts and derivatives of barbituric acid, also known as malonyl urea, having hypnotic or somnifacient action, and compounds, preparations, and mixtures thereof.

(B) "Delivery" means sale, dispensing, giving away, or supplying in any other manner.

(C) "Patient" means either of the following:

(1) The individual for whom a barbiturate is prescribed or to whom a barbiturate is administered;

(2) The owner or the agent of the owner of the animal for which a barbiturate is prescribed or to which a barbiturate is administered.

(D) "Person" includes individual, corporation, partnership, and association.

(E) **"Practitioner" means a person licensed in this state to prescribe and administer drugs.**

(F) "Pharmacist" means a person registered with the state board of pharmacy as a compounder, dispenser, and supplier of drugs.

(G) **"Prescription" means a written order, and in cases of emergency, a telephonic order, by a practitioner to a pharmacist for a barbiturate for a particular patient, which specifies the date of its issue, the name and address of such practitioner, the name and address of the patient, and, if such barbiturate is prescribed for an animal, the species of such animal, the name and quantity of the barbiturate prescribed, the direction for use of such drug, and the signature of such practitioner.**

(H) "Manufacturer" means persons other than pharmacists who manufacture barbiturates, and includes persons who prepare such drugs in dosage forms by mixing, compounding, encapsulating, entableting, or other process.

(I) "Wholesaler" means persons engaged in the business of distributing barbiturates to persons included in any of the classes named in divisions (A) to (G), inclusive, of section 3719.25 of the Revised Code.

(J) "Warehouseman" means a person who stores barbiturates for others and who has no control over the disposition of such barbiturates except for the purpose of such storage.

Prohibition Against Delivery

Sec. 3719.24. No person shall:

(A) Deliver any barbiturate unless:

(2) **Such barbiturate is delivered by a practitioner in the course of his practice and the immediate container in which such drug is delivered bears a label on which appears the directions for use of such drugs, and the name and address of such practitioner, the name and address of the patient, and, if such drug is prescribed for an animal, a statement showing the species of the animal.**

(B) **Refill any prescription for a barbiturate unless so designated on the prescription by the practitioner.**

(C) Deliver a barbiturate upon prescription unless the pharmacist who filled such prescription files and retains it as required by division (B) of section 3719.26 of the Revised Code.

(D) Possess a barbiturate unless such person obtained such drug on the prescription of a practitioner or in accordance with division (A) (2) of this section or from a person licensed by the laws of any other state or the District of Columbia to prescribe or dispense barbiturates.

(E) Refuse to make available and to accord full opportunity to check any record or file as required by section 3719.27 of the Revised Code.

(F) Fail to keep records as required by divisions (A), (B), or (C) of section 3719.26 of the Revised Code.

(H) Obtain or attempt to obtain a barbiturate by fraud, deceit, misrepresentation, or subterfuge; or by the forgery or alteration of a prescription; or by the use of a false name or the giving of a false address.

Any practitioner who gives a prescription to a pharmacist by telephone shall give a written

prescription to such pharmacist within seventy-two hours after such telephone message.

Exceptions

Sec. 3719.25. Division (A) and (D) of Section 3719.24 of the Revised Code do not apply to the delivery of barbiturates to persons included in any of the classes named in this section, or to the agents or employees of such persons, for use in the usual course of their business or practice or in the performance of their official duties, or to the possession of barbiturates by the following persons or their agents or employees for such use:

(A) Pharmacists;

(B) Practitioners;

(C) Persons who procure barbiturates for disposition by or under the supervision of pharmacists or practitioners employed by them, or for the purpose of lawful research, teaching, or testing, and not for resale;

(D) Hospitals and other institutions which procure barbiturates for lawful administration by practitioners;

(E) Officers or employees of federal, state, or local governments;

(F) Manufacturers and wholesalers;

(G) Carriers and warehousemen.

Keeping of Records

Sec. 3719.26. (A) **Persons, other than carriers, to whom section 3719.25 of the Revised Code is applicable shall:**

(1) Make a complete record of all stocks of barbiturates on hand on August 12, 1949, and retain such record for not less than two calendar years immediately following such date;

(2) Retain each commercial or other record relating to barbiturates maintained by them in the usual course of their business or occupation, for not less than two calendar years immediately following the date of such record.

(B) Pharmacists shall, in addition to complying with division (A) of this section, retain each prescription for a barbiturate received by them, for not less than two calendar years immediately following the date of the filling or the date of the last refilling of such prescription, whichever is the later date.

(C) A practitioner shall, in addition to complying with division (A) of this section, keep a record of all such barbiturates administered, dispensed, or professionally used by him otherwise than by prescription, for not less than two calendar years immediately following the date of the last administering, dispensing, or professional use; such record shall give the name and address of the patient, but need not be kept when the amount administered, dispensed, or professionally used in the treatment of any one patient does not exceed twelve grains in any forty-eight consecutive hours.

Inspection of Files

Sec. 3719.27. Persons required by section 3719.26. of the Revised Code, to keep files or records shall, upon the written request of an officer or employee designated by the state board of pharmacy, make such files or records available to such officer or employee, at all reasonable hours, for inspection and copying, and accord to such officer or employee full opportunity to check the correctness of such files or records, including opportunity to make inventory of all stocks of barbiturates on hand. No person shall fail to make such files or records available or to accord such opportunity to check their correctness.

(I) Whoever violates sections 3719.23 to 3719.28, inclusive, of the Revised Code shall be fined not more than five hundred dollars or imprisoned not more than one year, or both.

A Recent Opinion of the Attorney General

The following opinion recently given by Attorney General William Saxbe is in regard to the care of a non-tuberculous patient in the Ohio Tuberculosis Hospital.

(1) When a patient admitted to the Ohio tuberculosis hospital under the provisions of Sec. 3701.63, R. C., is found not to have tuberculosis, but is continued temporarily in a patient status under the provisions of Sec. 3701.65, R. C., and the county of his residence is being reimbursed in full for the cost of his hospital care, such a patient is hospitalized under Secs. 3701.60 to 3701.64, inclusive, R. C., and the auditor of state is required to transmit to the board of county commissioners of such county a statement of the amount due for such care and treatment less a credit of one dollar and twenty-five cents per day as provided in Sec. 3701.64, R. C.

(2) Under the provisions of Sec. 3701.65, R. C., the county is required to pay the state the expenses of care and treatment of a non-tuberculous patient only when the county is being paid back in complete measure for such expense.

(3) The director of health has no authority to make a determination of how much of the per diem rate a non-tuberculous patient is able to pay and bill the county commissioners of the county of his residence for an amount less than the full charge for his care and treatment.—Opinion No. 2683.

Poison Control . . .

In Cooperation with Existing Facilities, OSMA Committee Studies Plans To Extend Services Available to Physicians Toward a State-Wide Program

THIS report of the Ohio State Medical Association's Committee on Poison Control was prepared by Dr. John A. Norman, Akron, the committee's chairman. Ohio has six poison information centers in operation. This report will bring readers up to date on what is being done to widen the field and coordinate efforts toward state-wide coverage.

* * *

For many years the problem of accidental ingestion of poisonous substances, particularly by children, has been a gradually increasing one recently compounded by the rapid advance in the variety and complexity of commercial products and their ready accessibility to children in the home. Physicians often find themselves confronted with a child who has swallowed a product the chemical properties or potential poisoning effect of which is unknown or uncertain.

In an attempt to solve this problem a number of metropolitan areas have established through their own local efforts a centralized point for information pertaining to various poisons and designated as a Poison Information Center. For several years physicians in a few Ohio cities have enjoyed the services of such locally operated poison information centers and have found them to be a workable method of reducing the guesswork in the treatment of potentially poisoned individuals. Many smaller communities have appreciated the need for a poison information center but the difficulties of establishing and effectively maintaining it is greater than their local resources can provide.

In order to bridge the gap and provide this service equally to all physicians, the Ohio State Medical Association has established a Committee on Poison Control to work out plans for extending this service to every physician practicing in Ohio. At the present time six poison control centers have been established and are in operation throughout the state. These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. As a matter of convenience the location, address, and telephone number of each of these Ohio centers is noted in the box on facing page. It is suggested that this information be placed near the office telephone and home telephone of every physician.

Activities of OSMA Committee

At the request of the OSMA House of Delegates, the Committee on Poison Control has been exploring the feasibility of a "single central poison control center for Ohio."

Until this study is complete and until findings indicate a recommendation either for or against such a project, a primary function of the Committee on Poison Control is to work with the existing poison information centers of the State and to encourage their accessibility and promote their efficient utilization.

Also at the request of the House of Delegates, the Committee has under consideration a model legislative proposal drafted by the Committee on Toxicology of the AMA, dealing with the accurate and uniform labeling of hazardous household and industrial chemicals. Conferences with retailing and manufacturing groups, the State Pharmaceutical Association and other interested agencies are being conducted with regard to the possibility of presenting this legislation to the Ohio General Assembly in 1959.

In accordance with the House of Delegates resolution, the Committee has under discussion plans for furthering an educational program on prevention of accidental poisoning.

Many Products on Market

With some 250,000 different commercial products on the market, not to mention the thousands of drug products, it is not possible for anyone to be informed as to the contents of more than a few of them. Even the most extensive toxicology library would index perhaps only a few thousand toxic items. Labels on commercial products often give little or no clue to the chemical composition of the contents and the absence of the word "poison" on the label certainly does not imply that the contents of the particular container can be ingested without harm. Many substances in everyday use are not commonly recognized to be toxic if ingested, yet each year a number of deaths occur from such everyday products as furniture polish and cleaning compounds.

Most physicians have at times been in a position of deciding on proper management of a

Poison Information Centers in Ohio Currently in Operation

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	Kettering Laboratory University of Cincinnati Eden Avenue	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

Clip this box and post near telephone

potentially poisoned individual, usually a child, who has taken a quantity of an agent whose toxic properties are uncertain. A telephone call to a druggist or even to the manufacturer of the product may fail to provide the needed information, or may reveal the substance to be such a complex chemical compound as to further confuse the issue.

The usual recourse to gastric lavage in every such instance may often subject the small child to a most upsetting experience to remove a completely harmless agent from the stomach. Where authoritative information pertaining to a large number of products is made available promptly by telephone to the physician, unnecessary treatment can often be avoided and necessary treatment started without delay.

National Clearinghouse

Poison Information Centers have been proven to be effective in solving some of these problems in about 150 cities in the United States and Possessions. In the past two years the National Clearing House for Poison Information has been established in Washington, D. C., under the Department of Health, Education and Welfare. This center has proceeded to develop a growing file of indexed information compiled on filing cards, each card dealing with an individual agent or product and listing such products by brand names where appropriate.

These files are then printed and distributed to established Poison Information Centers throughout the country where they provide an up-to-date authoritative and relatively complete backbone for the local poison information center. Each month every local center receives an additional set of cards on a growing list of products to be added to its file.

An important feature of the information is the reference to the degree of toxicity of the substance, that is, how much of the product per kilogram of body weight would be expected to produce symptoms or fatality. Each card describes in detail the expected symptoms, time of onset, and the recognized therapy or appropriate antidote. The information on each card is reviewed for accuracy and completeness by three independent, competent authorities before release.

In addition to this card filing system each information center maintains a number of standard references which complete the library of the Poison Information Center.

Staffing The Center

In order for the information center to provide a competent service, it must be staffed by appropriately trained individuals who can obtain and transmit information to the attending physician by telephone day or night. To service the center, most communities have turned to the house staff of a hospital or to the Public Health Service. In this way a resident physician is available to answer any phone request for information from the Poison Library. In most instances he will function simply as an agent to search the available information and pass it along and will not convey his own opinions. He does not therefore act as a consultant nor does he accept any responsibility for the case in point. He is required to make a written report of every call answered and a re-

sumé of the information given and this will become a permanent record filed in the center.

So far only poison information has been mentioned. Most poison information centers operate in conjunction with a treatment facility such as a hospital emergency room. The information center, however, remains independent of the treatment facility and one information center may serve a large area with many facilities for carrying out appropriate treatment. This is what is anticipated in expanding the accessibility of the functioning centers to the whole state. The currently existing centers will expand their information service so that outlying communities will not necessarily be required to establish separate centers.

When The Center Is Called

If a physician has occasion to call upon a center with reference to a potential poisoning he will need to have certain basic facts in mind. These should include at least the following:

1. The full name or brand name of the product ingested or inhaled or, in the case of plant poisoning, the common and generic name if available.
2. An accurate estimation of the amount of the particular agent ingested or if this cannot be ascertained the maximum amount that could possibly have been ingested.
3. The time of ingestion.
4. The age and weight of the patient.

It is not to be implied that the poison information center can be depended upon for information about every possible agent that may serve as a poison. Certainly this is the eventual goal but at present only a relatively modest number of compounds have been indexed and filed. Nevertheless it would appear advisable that every physician contact the information center in his area about any poisoning agent the nature of which is uncertain or unfamiliar to him. Failure to do so would be regrettable if the patient were to experience an unfavorable outcome which could have been avoided. Most areas of Ohio are within a fifty cent toll call of a poison information center, according to information presented to the Committee.

The present program for poison control is only a beginning effort. Plans are in progress for augmenting the service with that of a qualified toxicologist for direct consultation. Safer "child proof" packaging and better labeling of common offending agents is being sought. A study of more effective public and professional education regarding poisons is under way. There is no reason that needless death and disability from poisoning should not be reduced in the next few years.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since September 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Franklin County

Donald Phillip Smith, Columbus

Hamilton County

(Cincinnati unless otherwise indicated)

George P. Balz
Roh Clauss
Ambrose H. Clement
Milton H. Clifford
Robert E. Gregory
Harold B. Hines
Henry J. Kenkel
Frank E. Kuller
Glen E. McPheron
Robert G. Nugent
John F. Popken
Joseph E. Russell
George E. Russo
Jack D. Selzer
John E. Williams
Robert C. Kratz, Ft. Thomas, Ky.

Lorain County

Charles C. Brausch, Avon Lake

Lucas County

Edward J. Kurt, Toledo

Montgomery County

Junius E. Cromartie, Jr., Dayton
Joachim H. Wittoesch, Dayton

Ohioans Included in Insurance Grants for Heart Study

The Life Insurance Medical Research Fund has given 81 awards—two of them in Ohio—totalling $1,098,680 in support of heart research during the coming year. The awards in Ohio both go to Western Reserve University School of Medicine. The first is for research by Dr. Robert M. Berne on the synthesis and utilization of fat by the heart, $11,550; the second, for research by Dr. Henry Rudney on the biosynthesis of cholesterol precursors, $29,700 (the largest award given).

Robert W. Bernlohr, Ph. D., Columbus, was awarded a fellowship by the same fund for study with Dr. G. D. Novelli at the Oak Ridge National Laboratory, Oak Ridge, Tenn. His was one of 24 such fellowships awarded.

Ohio Physicians Participate In Bahamas Conference

Physicians who wish to combine a vacation trip with attendance at a medical conference will be interested in the Bahamas Medical Conference to be held in Nassau, Bahamas, November 28 - December 18.

Three Cleveland physicians are participating on the program. They are Dr. Henry A. Zimmerman, director, Cardiovascular Center, St. Vincent Charity Hospital; Dr. E. Perry McCullagh, Department of Endorcrinology and Metabolism, Cleveland Clinic, and Dr. Charles H. Brown, Section on Gastrointestinal Diseases, Division of Medicine, Cleveland Clinic.

Workmen's Compensation . . .

A Report on How Much Was Expended Through the State Agency for Medical Services to Ohio Workers; Breakdown Shows Other Expenditures

THE Ohio Bureau of Workmen's Compensation during the calendar year 1957 paid out $7,827,104.24 for medical services to injured Ohio workers, according to information provided by the Actuarial Section of the Bureau. That amount excluded a small sum for dental services.

Other 1957 expenditures, exclusive of compensation payments, included the following: $9,749,720.37 for hospital care and nursing; $214,444.22 for funeral expenses, and $61,179.26 for miscellaneous costs. With disbursements for medical expenses added, the total is $17,842,448.09.

These amounts include payments covering treatment of injured private and public employees as well as similar costs for occupational disease claims.

Comparative figures for 1956 were as follows: $8,117,236.42 for medical services; $9,641,846.76 for hospital care and nursing; $246,935.16 for funeral expenses, and $81,742.43 for miscellaneous costs; a total of $18,087,760.77.

The number of claims filed during 1957 was 329,894 or 3.8 per cent less than in 1956.

"Medical-only" claims filed involving payments for physicians' services, but with no compensation for the claimant for loss of time, numbered 263,400 for 1957, or 80 per cent of all claims filed. The average amount paid out for "medical-only" claims increased from $17.80 in 1956 to $22.72 in 1957.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives the 1957 awards that have been made to active claims according to the year of injury and having injury dates which in some cases reach back to the beginning of the fund in 1912.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

As of December 31, 1957

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 1,697,130.44	$ 83,726.31	$ 6,148.37	$ 21,338.45	$ 1,808,343.57
Bonds	269,233,368.15	13,285,821.87	969,370.77	3,399,564.21	286,888,125.00
Premiums in Course of Collection	43,703,560.48	6,866,604.19	16,183.69		50,586,348.36
Accrued Interest	668,705.18	32,989.94	2,422.59	8,407.80	712,525.51
Administrative Cost Assessment	613,589.80	4,145.30			617,735.10
Total Assets	$315,916,354.05	$20,273,287.61	$994,125.42	$3,429,310.46	$340,613,077.54

LIABILITIES

Reserve for Compensation and Medical	$256,939,373.74	$20,258,247.20	$137,756.00		$277,335,376.94
Advance Premium Deposits	41,480,966.80				41,480,966.80
Administrative Cost Assessment		1,538.01			1,538.01
Fund				$3,429,310.46	3,429,310.46
Reserve for Contingencies and Surplus	17,496,013.51	13,502.40	856,369.42		18,365,885.33
Total Liabilities	$315,916,354.05	$20,273,287.61	$994,125.42	$3,429,310.46	$340,613,077.54

TABLE 2 — PRIVATE FUND

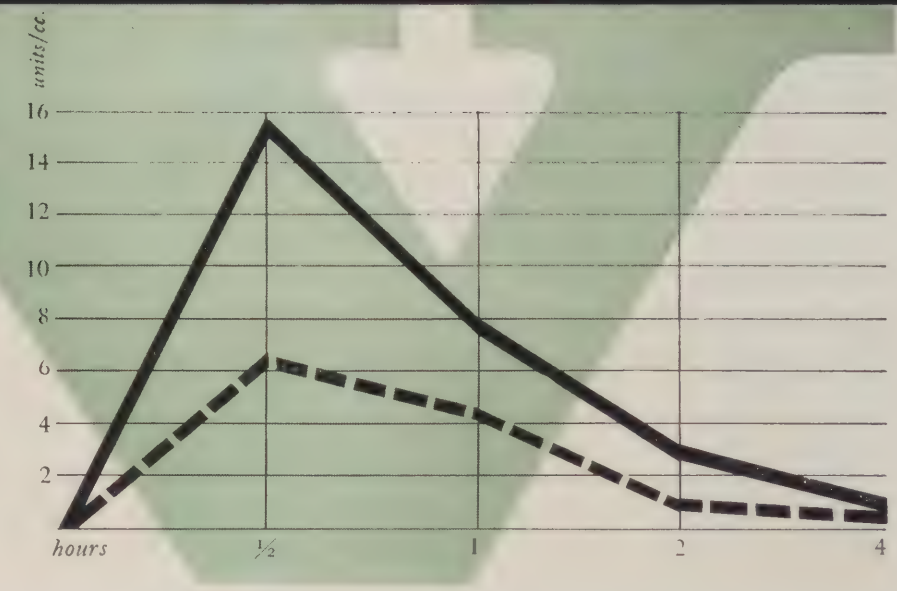
Medical, Hospital, etc., Awards Distributed to Year of Injury Occurrence

(Accident and Occupational Disease Combined)

Year of Accident or Disease	Awarded	1957 Per Cent	1956 Per Cent
1957	$ 6,698,990	37	41
1956	4,931,667	28	29
1955	1,416,835	8	7
1954	798,965	4	5
1953	555,490	3	4
1952	402,907	2	3
1951	684,151	4	2
1950	359,620	2	2
1949	302,736	2	1
1948	255,934	1	1
1912-1947	1,568,598	9	5
Total	$17,975,893	100	100

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The median levels of Filmtab Compocillin-VK.

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AMA Clinical Meeting . . .

December 2-5 Program in Minneapolis Will Feature Programs of Interest In Everyday Practice; Timely Exhibits, Trans-Atlantic Conference, etc.

OHIO doctors will join more than 3,000 physicians expected to attend the American Medical Association's 12th clinical meeting December 2 - 5 in Minneapolis.

Designed to help the family physician solve his daily practice problems, the meeting has been planned in cooperation with Minneapolis physicians. General chairman of the meeting is Dr. O. L. Norman Nelson, Minneapolis, president of the Hennepin County Medical Society. Dr. N. L. Gault, Jr., Minneapolis, is the scientific program chairman.

This is the fifth time the AMA has met in the Twin Cities, although it is the first clinical session. Annual meetings were held in Minneapolis in 1913 and 1928 and in St. Paul in 1882 and 1901.

The scientific portion of the program will be held in Minneapolis Auditorium, while the House of Delegates will meet at the Leamington Hotel, headquarters for the meeting.

Scientific Exhibits

In Minneapolis Auditorium will be 100 scientific exhibits prepared by physicians and the AMA Council on Scientific Assembly. Among them will be exhibits on medical history in Minnesota, including information about Indian medicine and the Mayo Clinic.

There will also be approximately 130 technical exhibits presented by pharmaceutical houses, medical equipment manufacturers, food processors, medical book publishers and other commercial organizations.

Approximately 200 physicians will participate in lecture meetings, symposiums, and panel discussions on such subjects as neurology and psychiatry, cardiovascular disease, arthritis, orthopedics and various other medical topics.

Approximately 35 medical motion pictures will be shown in Minneapolis Auditorium. A special feature will be a symposium on proctology Wednesday evening, December 3. Moderated by Dr. Raymond Jackman, Mayo Clinic, it will include three films made by Dr. Jackman; Dr. Malcolm Hill, Los Angeles, and Dr. Lawrence Abel, London, England.

Trans-Atlantic Conference

Another special feature of the meeting will be a trans-Atlantic conference between AMA members in Minneapolis and British Medical Association members in Southampton, England. It is scheduled for Friday, December 5. The British association will be holding a clinical session at that time.

Closed circuit colored television again will be shown to doctors attending the meeting. It will be sponsored by Smith, Kline and French Laboratories, Philadelphia pharmaceutical house. Programs originating in the Mayo Memorial Building of the University of Minnesota Hospital will be shown in Minneapolis Auditorium. Among the topics will be cardiac by-pass, neurology, orthopedic problems of the extremities, and cesarian section.

The General Practitioner of the Year will be named Tuesday morning at the opening session of the House of Delegates. Dr. Cecil W. Clark, Cameron, La., was the last recipient of the award, given annually to an outstanding American doctor for his medical and civic contributions to his community.

The House of Delegates, members and their wives will hold a banquet Wednesday evening.

The Woman's Auxiliary to the AMA which will hold no regular meetings, will sponsor a series of tours for physicians' wives during the meeting.

Grant Helps Equip Cincinnati University Building

The purchase of $13,748 worth of health research equipment for the new medical research building of the University of Cincinnati College of Medicine has been made possible by the receipt of a grant for that amount from the National Institutes of Health, Department of Health, Education and Welfare, Dr. Stanley E. Dorst, dean of the college, announced.

The grant enabled the UC medical college to finish equipping the $1.7 million annex now under construction. Adjoining the main college building on Eden Ave., the four-story structure will be completed about February 1.

Each year, the company's statisticians report, about 6,000 children from 5 to 14 years of age are killed accidentally. This is two fifths of all the deaths in this age range.—*Metropolitan Life.*

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Aspirin (Acetylsalicylic Acid)	gr. 3½

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Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

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Laboratory Services . . .

Report of Committee Based on Survey of 238 Laboratories Throughout State; Recommendations Are Offered on Ways To Improve Work Done

AT a meeting of the Committee on Public Relations and Economics in the Fall of 1957, there were hearings and discussions on the needs for and methods of improving the quality of clinical laboratory work available to the physicians of Ohio, a subject covered in a resolution adopted by the House of Delegates at the 1957 Annual Meeting.

A subcommittee headed by Dr. H. B. Davidson, Columbus, a member of the main committee, was selected to prepare and present recommendations. The subcommittee members in addition to Dr. Davidson were: Edward L. Burns, M.D., Toledo; Mel A. Davis, M.D., Columbus; Edward A. Gall, M.D., Cincinnati; John B. Hazard, M.D., Cleveland; Ralph J. Johansmann, M.D., Columbus; Melvin Oosting, M.D., Dayton; Robert J. Ritterhoff, M.D., Cincinnati; William Sinclair, Jr., M. D., Cleveland; William B. Smith, M.D., Zanesville; Philip B. Wasserman, M. D., Cincinnati, Arthur E. Rappoport, Youngstown.

When the subcommittee found itself in need of certain basic information it sent a questionnaire to medical laboratories in the state. Reports were received from 238 laboratories.

After consideration of the tabulated survey findings, the subcommittee drew up a set of recommendations for a course of action which seemed advisable at present. These recommendations were approved by the Committee on Public Relations and Economics and subsequently ratified by The Council. The recommendations are as follows:

1. Supervision:

1. Clinical laboratory work is part of the practice of medicine and should be under the supervision of a physician.

2. A physician with special training in laboratory work is a pathologist and therefore clinical laboratory work should be under the supervision of a pathologist.

3. A full time M.D. pathologist is desirable if available; a part time M.D. pathologist is desirable if a full time one is not available; an M.D. supervisor with an M.D. pathologist consultant is desirable if no more extensive arrangement can be made.

4. Encourage hospitals to make some arrangement for M.D. supervision and at least M.D. pathologist consultant service for their laboratories, and help them find a pathologist.

2. Technicians:

1. The best technician training is that outlined by the Registry of Medical Technologists of the American Society of Clinical Pathologists, and such technicians should be utilized wherever possible, or available.

2. If they are not available the technician should have a degree in biologic science.

3. Where non ASCP technicians are necessary, they should be under the supervision of an ASCP trained technician.

4. In order to increase the available number of ASCP trained technicians and to keep good faith with them, all possible aid and help should be given toward their recruitment and toward the betterment of their working conditions including salary.

3. Education:

1. Sponsor programs for directors of laboratories at the time and place of the Annual Ohio State Medical Association Meeting and with programs aimed at new methods and their significance, practical help and advice on existing methods and aids to and methods of insuring accuracy in laboratory work.

2. Sponsor technician training and refresher courses with programs containing the same topics covered in (1) above, given in various regions of the state and given under the auspices of the Ohio State Medical Association.

3. The establishment of a consultation service made up of competent members of the Ohio State Medical Association who are willing to offer their services including time and advice to the laboratories of the state which feel the need of help.

4. To prepare and distribute periodic informational bulletins with practical information on methods and accuracy.

4. Evaluation:

1. This evaluation to be a self evaluation with the aid of standards, controls and unknowns supplied through or by the sponsoring committee from sources such as the College of American Pathologists and the Ohio Department of Health.

5. Development:

1. Encourage and aid in the development of reference or referral laboratories in strategic areas of the state to carry out the more difficult or

less frequently performed types of tests which are not ordinarily available in smaller laboratories and to thereby obviate the necessity of small hospital laboratories referring this type of work to lay laboratories.

2. To develop laboratory services of a type and quality which appear to be needed to meet current trends and developments before this need is exploited by some outside group or before the absence of such services is criticized by some outside group.

6. Activation:

These various endeavors and activities to be carried out by a committee on Laboratory Medicine to be established as a committee of the Ohio State Medical Association, and similar to the present Committee on Maternal Health, Committee on Cancer, Committee on Mental Hygiene and Committee on Rural Health.

The essence of the plan is to provide leadership and offer help to hospital and physician operated laboratories of the state in the provision of proper medical supervision, and properly trained technicians, the maintenance of satisfactory standards of accuracy and in making available a reasonably complete variety of procedures. This is to be done by a permanent committee of the Ohio State Medical Association made up of interested and qualified members.

Cincinnati Academy Adopts Code On Industrial Medicine

The Academy of Medicine of Cincinnati has adopted a code intended to clearly define the scope, objectives, and functions of occupational health programs in Hamilton County. It is in accordance with the general principles of the American Medical Association as published in their booklet "Scope, Objectives and Functions of Occupational Health Programs."

The code states in a positive fashion the place of occupational health programs in the practice of medicine and charts the pathway of communication between physicians in occupational health programs and physicians in the private practice of medicine. The Academy of Medicine of Cincinnati has promulgated this code to establish a better understanding between physicians in the private practice of medicine and those in industrial medicine. Text of the code follows:

Definitions: Occupational health programs are programs provided by management to deal constructively with the health requirements of employees and employers in relation to employment. Industrial Medicine is that branch of medicine practiced by physicians in meeting medical problems and needs under occupational health programs.

Objectives: (1) To promote improvement of health of employees through preventive medicine techniques, such as health education and periodic health examinations.

(2) To examine prospective employees in such a manner as to assure placement on a job which will not be harmful to the employee. To repeat physical examinations when warranted for job reassignment.

(3) To protect employees against extraordinary health hazards in their work environment through periodic examinations.

(4) To immunize employees with tetanus toxoid and immunizations required and incidental to overseas employment; all other immunizations are to be administered by the employee's personal physician.

(5) To transfer all nonoccupational conditions to the care of the personal physician of the employee's choice.

(6) To provide emergency medical service to prevent loss of life and relief of suffering until the employee is placed under the care of a physician of his choice.

(7) To accept the responsibility and direction of treatment of an employee suffering from an occupational disease or injury and, when indicated, refer the employee to a qualified physician for indicated care.

(8) To co-operate with community health services.

(9) To encourage reciprocal relationships with personal physicians that lead to the best health interest of employees, such as,

(a) Encourage employees to have personal physicians.

(b) Upon consent of employee, provide mutual exchange of medical records.

(c) To encourage the personal physician to observe and evaluate the working environment of the employee.

A grant of $22,700 by the National Science Foundation, Washington, D. C., to the University of Cincinnati is for a study to determine the possibility of controlling snails which transmit human blood flukes. Dr. Frank J. Etges, assistant professor of zoology at the University, will be principal investigator.

Motor vehicle accidents far outrank all other types of fatal accidents among women under 65 years of age, and most of these women killed are passengers or drivers rather than pedestrians.—*Metropolitan Life.*

In Memoriam . . .

William W. Baker, M. D., Steubenville, Meharry Medical College, 1920; aged 64; died September 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Baker had been a practicing physician in Steubenville for the past 36 years. He was a member of the Elks Lodge, the Masonic Lodge and the Baptist Church. Surviving are his widow and a son.

Everett T. Bonar, M. D., La Jolla, Calif.; Ohio State University College of Medicine, 1920; aged 65; died September 28; member of the Ohio State Medical Association and the American Medical Association. A native of Rockport, W. Va., and early resident of Woodsfield, Dr. Bonar began his practice in Springfield where he was surgeon for the International Harvester Company. He moved to Columbus in the early 1920's and remained in practice there until about five years ago when he retired. He had been living in California for about two years. He was a member of the Masonic Lodge, the Order of the Eastern Star and the Community Church. Surviving are his widow, a daughter, a granddaughter, a sister and two brothers, one of whom is Dr. Elwood D. Bonar, of Columbus.

George H. Bonnell, M. D., Worthington; Starling Medical College, Columbus, 1906; aged 77; died September 12; member of the Ohio State Medical Association and the American Medical Association. Honored with the 50-Year Award of the OSMA, Dr. Bonnell had been a practicing physician in Worthington for many years. He was a member of the local school board for 16 years. Surviving are his widow; a son, Dr. George H. Bonnell, Jr., also of Worthington; two daughters, two stepsons and a brother.

James A. Coleman, M. D., Toledo; Toledo Medical College, 1898; aged 91; died September 20; member of the Ohio State Medical Association and the American Medical Association. A native of Toledo, Dr. Coleman practiced for virtually a lifetime there and was honored with the 50-Year Award of the OSMA. He was a member of the Catholic Church and the Knights of Columbus.

John J. Coletta, M. D., Columbus, Hahnemann Medical College and Hospital of Philadelphia, 1934; aged 50; died September 22. Dr. Coletta practiced his profession for 24 years in Columbus. He was a member of the Catholic Church. Surviving are his widow, his father, two brothers and three sisters.

John W. Conwell, M. D., Cleveland; Western Reserve University School of Medicine, 1918; aged 67; died September 23; former member of the Ohio State Medical Association and the American Medical Association. Long a practicing physician in Cleveland, Dr. Conwell was active in a number of organizations there. He was a member of the Medical Library Association and formerly played with the Doctors Symphony Orchestra of Cleveland. He was active in Boy Scout work, was a member of the Rotary Club, and several Masonic bodies. Surviving are his widow, a daughter and a son, Dr. John W. Conwell, Jr.

H. Wilbur Cooper, M. D., Lakewood; University of Michigan Medical School, 1900; aged 87; died September 6; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Cooper practiced medicine for about 30 years in the Greater Cleveland area, and previously was a resident of Steubenville. His widow survives.

Nora Crotty, M. D., Cincinnati; Cincinnati College of Medicine and Surgery, 1902; aged 89; died September 14; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Crotty practiced for more than a half century in Greater Cincinnati, most of that time in the Clifton area. She was a member of the Catholic Church and the Catholic Ladies of Columbia. Survivors include two sisters and three brothers.

Eugene E. Elder, M. D., Miami Beach, Florida; University of Budapest, Hungary, 1922; aged 68; died October 3; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association. Dr. Elder retired only recently after 13 years as superintendent of the Woodside Receiving Hospital in Youngstown. Prior to that assignment he was at the Massillon State Hospital. He was a member of the Temple, the Zionists and B'nai B'rith. His widow and three brothers survive.

Alfred M. Glazer, M. D., Cincinnati; University of Michigan Medical School, 1929; aged 52; died September 26; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Glazer began his practice in Cincinnati after completion of his medical training and for 25 years was on the faculty of

the University of Cincinnati College of Medicine, in the Department of Internal Medicine. He is survived by his widow, two sons and four brothers.

Harold G. Haines, M. D., Berlin, Penn.; University of Pittsburgh School of Medicine, 1920; aged 63; died September 16 as the result of an explosion and fire in his home. Dr. Haines practiced in Warren from 1920 to 1935, in which year he moved to Pennsylvania. Surviving are a son, his parents and a sister. His wife perished with him in the blaze.

Herman E. Heston, M. D., Ocoee, Tenn.; Starling Medical College, Columbus, 1896; aged 83; died September 19; former member of the Ohio State Medical Association. Dr. Heston practiced in Columbus from 1904 to 1919 and again from 1929 to 1945. A son survives.

Robert A. Keating, M. D., Columbus; Ohio State University College of Medicine, 1937; aged 47; died October 7; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons and specialist in urology. Dr. Keating's entire professional career was served in the Worthington and Columbus area except for time served in the Navy Medical Corps during World War II. He was a member of Phi Rho Sigma. Survivors include his widow, a son, a daughter and his mother.

Delbert V. Kechele, M. D., Bluefield, W. Va.; Western Reserve University School of Medicine, 1920; aged 66; died September 13; member of the American College of Radiology; diplomate of the American Board of Radiology. Dr. Kechele practiced for 22 years in Olmstead Falls before he moved to West Virginia in 1942. Among organizations to which he belonged was the Masonic Lodge. Surviving are two sons, a daughter and a brother, Dr. O. J. Kechele, of Berea.

Sidney N. Mendelsohn, M. D., Cincinnati; University of Louisville School of Medicine, 1929; aged 53; died October 4; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. Dr. Mendelsohn practiced his profession in Cincinnati for 28 years. He is survived by his widow, a son, a daughter, two sisters and three brothers, one of whom is Dr. Harry Mendelsohn, of Madisonville in Greater Cincinnati.

James H. Riley, M. D., Norwalk, Conn.; Ohio State University College of Medicine, 1912; aged 69; died September 7; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. Dr. Riley retired in 1957 after 44 years of practice in Springfield. He was a veteran of World War I, having served with the Army Medical Corps during that war. Survivors include a daughter and a brother.

Earl J. Powers, M. D., Winston Salem, N. C.; University of Cincinnati College of Medicine, 1932; aged 53; died September 28. After completing his medical education in Cincinnati, Dr. Powers practiced for a short time in Washington C. H. before he left the state.

Wiley W. Scott, M. D., Orlando, Fla.; University of Wooster Medical Department, Cleveland, 1909; aged 77; died September 7; member of the Ohio State Medical Association and the American Medical Association; past-president of the Canton Academy of Medicine and former treasurer of the Stark County Medical Society. Dr. Scott practiced medicine in Canton from 1919 to 1946, in which year he retired. Before moving to Canton he practiced in Bolivar. Surviving are his widow, a son and a daughter.

William H. Wilson, M. D., Greenfield; Medical College of Ohio, Cincinnati, 1897; aged 84; died September 7; member of the Ohio State Medical Association and the American Medical Association. A native of the Greenfield area, Dr. Wilson returned there to practice following service in the Spanish-American War. He had been honored with the 50-Year Award of the OSMA. For many years he served on the Highland County Board of Health. Other organizations to which he belonged included several Masonic bodies, the Methodist Church and the Rotary Club. Surviving are his widow, a daughter, a son and a sister.

New Guide To Measure Visual Impairment Published

A set of uniform standards for measuring visual loss and its effect on a person's ability to perform daily activities has been published by the American Medical Association.

For years doctors and laymen have tried to answer the questions: How does a visual deficiency influence a person's ability to live a normal life? How can the degree of impairment of this ability be measured?

The new guide "seeks to provide a simplified method for determining visual impairment and the extent of its effects on an individual's ability to perform the activities of daily living," according to an editorial in the September 27 *AMA Journal,* in which the guide appears.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

June 19, 1958—Vladimirus Bazali, University of Innsbruck, Austria; Martin E. Felder, Columbus, Tufts College Medical School; Roderic O. Jones, Zanesville, Duke University; Walter W. Kolatalo, University of Marburg, Germany; Maurice L. Lewis, Lima, State University of Iowa; Robert F. Lewis, Trotwood, University of Louisville;

Foster Marshall II, Columbus, Medical College of South Carolina; Frederick W. O'Brien, Cleveland Heights, Tufts College Medical School; Zdzislaw J. Rodzinski, University of Cracow, Poland; Morris H. Sable, Cleveland, Chicago Medical School; Thomas C. Sweeney, Cleveland, Northwestern University; Kolbein K. Waering, Nelsonville, Harvard Medical School.

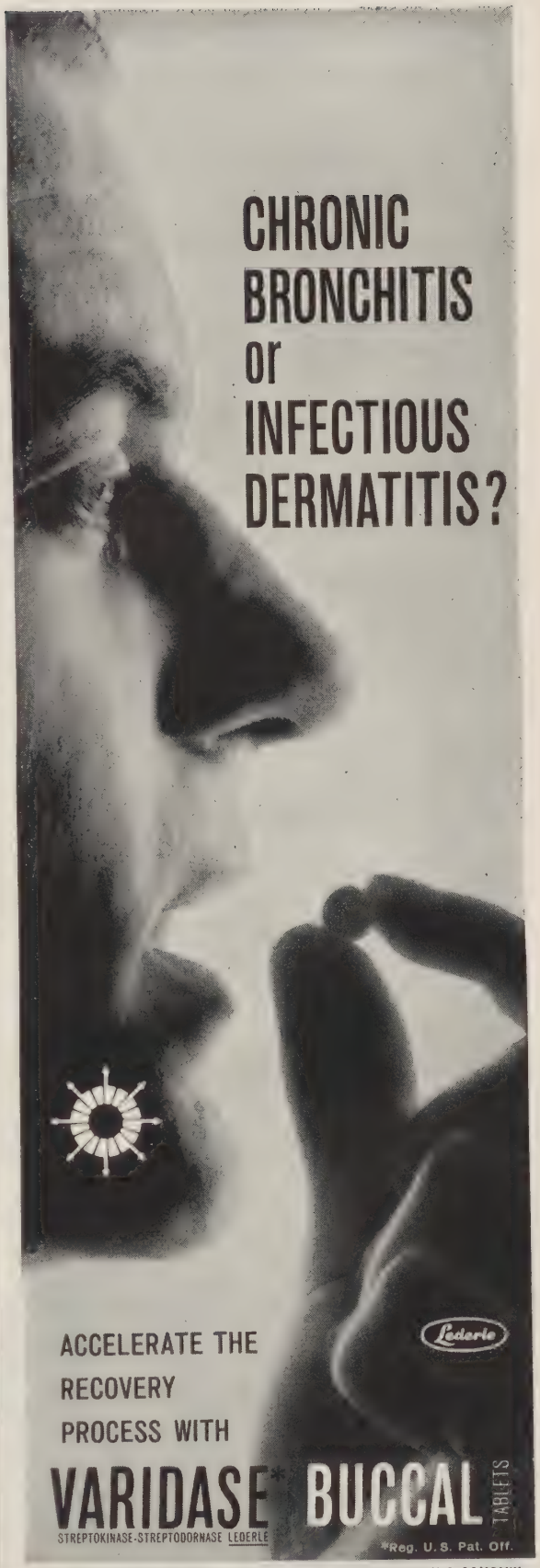
August 19—Marvin R. Agran, Youngstown, Chicago Medical School; Ernest E. Alvin, Jr., Youngstown, Hahnemann Medical College; Elio Baldini, University of Bologna, Italy; Gordon K. Bell, Canton, University of Ottawa; Horst N. Bertram, Dayton, University of Berlin, Germany; Lyle W. Burroughs, Columbus, Washington University; Harvey R. Butt, Jr., Columbus, University of Maryland;

Cahit Corbacioglu, Cleveland, University of Ankara, Turkey; Thomas L. Curtin, Columbus, University of Southern California; David C. Davis, University of Virginia; Alexander P. Demidov, New Lexington, Imperial University of Moscow, Russia; Alice F. Fisher, Cincinnati, University of Rochester; Francis J. Froehlich, Cincinnati, State University of New York;

Herbert W. Goebert, Jr., Warrensville Heights, Hahnemann Medical College; Charles W. Hannah, Sardinia, Indiana University; Herndon P. Harding, Worthington, College of Medical Evangelists; Fleurene P. Holt, Youngstown, Syracuse University; Clyde O. Hurst, Tulane University; Ward S. Jenkins, Toledo, Yale University; Francis E. Kelly, Dayton, New York Medical College;

George M. Leiby, Columbus, Vanderbilt University; Albert M. Lewis, Cleveland, Loyola University; Ping Chung Ling, Marion, University of Arkansas; William D. Loeser, Youngstown, University of Buffalo;

Foster A. McVicker, Bellaire, University of Pittsburgh; John C. Mall, University of Punjab,



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NEW CHANCE FOR MEMBERS TO ENROLL IN GROUP LIFE PLAN OF OSMA FROM NOVEMBER 15 TO DECEMBER 31; WATCH FOR LETTER

MEMBERS of the Ohio State Medical Association and their employees will have another opportunity on November 15 to enroll in the Ohio State Medical Association Group Life Insurance Plan. A letter regarding this is being sent to members by Turner & Shepard, 20 S. Third Street, Columbus 15, administrators of the plan.

Members and employees who did not enroll during the first enrollment period which ended last September 18 will be able to subscribe during the period November 15 to December 31 for the same coverage and at the same rates as during the initial enrollment period.

If 1,000 or more members and their employees subscribe during the November 15 - December 31 period, any one of them may obtain coverage for $10,000 without showing evidence of insurability and an additional $10,000 by showing evidence of insurability.

If less than 1,000 members and employees enroll during the November 15 - December 31 period, only those showing evidence of insurability will be issued a contract.

As of October 20, approximately 2,000 members and their employees have enrolled and been issued contracts.

The rule on new members is that a new member may at any time within 90 days of becoming a member, apply for the OSMA group life coverage without showing evidence of insurability.

India; Alfred F. Michael, Jr., Cincinnati, Temple University; Henry A. Miller, Cleveland, Stanford University; Kenneth L. Miller, Cleveland, Tufts College; Warren N. Morford, Sr., Proctorville, University of Louisville; Thomas F. Moriarty, Jr., Napoleon, University of Louisville; Lyle Moses, Shaker Heights, University of Illinois; Henry L. Murphy, Cincinnati, Meharry Medical College; James A. Murray, Fostoria, Jefferson Medical College;

George Naymick, Medical College of Virginia; Ellen Newman, Cleveland, Columbia University; James M. Orth, Akron, Northwestern University; Edward P. Passaro, Jr., Columbus, University of Rochester; Richard B. Peoples, Toledo, Jefferson Medical College; George B. Prozan, Cleveland, New York State University; Kathryn A. Rainbow, Oberlin, Meharry Medical College; Howard T. Robinson, Warren, Johns Hopkins University; Paul E. Roth, Northwestern University; David T. Rowlands, Jr., Cincinnati, University of Pennsylvania;

Ralph C. Schwarz, Cincinnati, St. Louis University; Howard C. Smith, Painesville, University of Buffalo; Charles E. Ward, Delaware, Medical College of Virginia; Jack C. Wilhoit, Cincinnati, University of Louisville; Charles B. Wilkinson, Cincinnati, Howard University; Raymond V. Wizbowski, Toledo, University of Michigan.

Symposium on Medical Technology Is Offered in Cleveland

The Frank E. Bunts Educational Institute (affiliated with The Cleveland Clinic Foundation) and The Cleveland Society of Medical Technologists offer a symposium on Medical Technology November 20 and 21. Applications are limited to 125 and will be honored in order received.

At the Symposium special attention will be given to the practical aspects of current and newly developed techniques. The program will be of interest to medical technologists and clinical laboratory supervisors.

On the day previous to the opening of the Symposium, there will be a limited number (absolute limit 20) of places available at a Parasitology Workshop directed by the Communicable Disease Center of Chamblee, Georgia.

The Cleveland Clinic is located at Euclid Avenue and East 93rd Street, and may be contacted for details.

With the continuing rise in the educational level, by 1975 more than one half of the adult population will have at least a high-school education, and almost one tenth will have received a college degree. Among the white male population, about one seventh will have completed college.—*Metropolitan Life.*



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SEARLE

*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

ALLEN

Dr. F. Mason Sones, of the Cleveland Clinic, was guest speaker for the September 16 meeting of the Allen County Academy of Medicine at the Shawnee Country Club in Lima. The subject of his talk was "Cine Fluorographic Studies in Cardiac Disease."

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

The Clark County Medical Society September 15 gave its endorsement to a proposal to build a new school for retarded children in Clark County.

The endorsement came in a society vote at the general meeting held in Hotel Shawnee, Springfield.

Voters here November 4 will decide if the county will get a new school for the children. The proposal on the ballot is for one-tenth of a mill for 10 years.

Sixty-eight persons, including 14 interns from Mercy and City Hospitals, attended the dinner meeting and heard Dr. Samuel Saslaw, professor of medicine at Ohio State University College of Medicine, talk about "Present Day Antibiotic Therapy."

Dr. Edwin A. Roberts, Dr. David D. Smith and Dr. Lincoln L. Moore were voted associate members for one year.—Tom Duross, Executive Secretary.

MIAMI

Dr. Thomas G. Skillman, assistant professor in the Department of Internal Medicine, Ohio State University, discussed the recent work with oral hypoglycemic agents to members of the Miami County Medical Society on September 12 at Dettmer Hospital.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PORTAGE

The regular meeting of the Portage County Medical Society was held September 16, at Robinson Memorial Hospital, Ravenna. After a business meeting, Mr. Sidney Mountcastle, executive secretary of the Summit County Medical Society, presented an outline of the program for the Sixth Councilor District Postgraduate Day in October. A film from the National Society for the Prevention of Blindness, on "Glaucoma" was presented, pointing out the advantages of screening for glaucoma by the general practitioner.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Following is an excerpt from a report in the *Youngstown Vindicator:*

Dr. George F. Lull, assistant to the president of the American Medical Association, urged physicians to greater participation in community problems before 200 members and wives of the Mahoning County Medical Society Saturday evening, Sept. 27.

At the Past Presidents Commemoration Banquet at the Hotel Pick-Ohio Ballroom, Dr. Lull said that "one of the chief afflictions among professional and business men in our complex society today seems to be a lack of interest in what the other fellow is doing."

Following his speech, Dr. Lull presented testimonial scrolls to 27 physicians who have held the office of president of the Mahoning County Medical Society. Dr. Andrew A. Detesco, president of the Society,introduced each past president.

Dr. Lull was introduced by Dr. C. A. Gustafson, councilor for the Sixth District of the Ohio State Medical Association and a past president of the Mahoning County Medical Society.

SUMMIT

The Summit County Medical Society had as guest speaker on October 7 Colonel Andres I. Karstens, deputy commander, Aero-Medical Laboratories, Wright-Patterson Air Force Base. Colonel Andres discussed tolerance to high altitude and space flying as well as the hazards and feasibility of space flight.

For the fourth successive year, the Summit County Medical Society is sponsoring a series of public forums, in cooperation with the University of Akron and the *Akron Beacon Journal.*

Discussions center around medical problems in three broad classifications. Topics for discussion are: "Problems of the Aged," "The Crippled, Deformed or Deficient Child," and "The Teen-Ager's Physical and Mental Problems."

TRUMBULL

At the October meeting of the Trumbull County Medical Society, Dr. Cyrus Maxwell, associate director of the Washington Office of the AMA, was the speaker of the evening. Dr. Maxwell dis-

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cussed problems that arise in Washington regarding legislation relating to medical and health matters.

Consideration of the affiliation of a portion of the Trumbull County Tuberculosis Hospital with Trumbull Memorial Hospital for use in handling patients with chronic diseases was sent back to committee for further study after the matter was presented before the Society at the last meeting.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

COLUMBIANA

Dr. Donald Effler, of the Department of Thoracic Surgery, Cleveland Clinic, was guest speaker at the dinner meeting of the Columbiana County Medical Society on September 23. His discussion was on the subject of "Open Heart Surgery."

TUSCARAWAS

Members of the Tuscarawas County Medical Society and the Tuscarawas County Bar Association with their wives held a joint meeting at the Union Country Club. Speaker for the occasion was Attorney Sherlock H. Evans, Massillon humorist, who spoke on "Pink Pills for Pale People." The get-together is planned as an annual event.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

HOCKING

The following is an excerpt of a report in the *Logan News:*

The Hocking County Medical Society voted its "unanimous approval of the progressive public health program developed during the past five years since passage of the public health levies."

The medical society also endorsed proposed renewal of levies for the health department and tuberculosis care, which will be voted on in November.

This was one of several matters taken up by the medical society.

The Hocking society appointed a committee to prepare a fee schedule, which later will be submitted for approval of the medical society, county commissioners and the county welfare department.

Members of the committee are Dr. J. Ward Doering, chairman; Dr. Owen F. Yaw and Dr. Petras Balsevicius.

The society also voted to endorse and approve the Logan city school board's action in requiring all pupils entering the first grade to be vaccinated against polio.

It was further recommended that the county school board urge all local boards to establish the same requirement for each of its respective schools.

Policy on Salk polio vaccine was set forth as follows: members of the medical society will vaccinate all of their own patients and will furnish vaccine for the health department to give to all pre-school children whose parents feel they cannot afford to pay for it, also to all pregnant women of all ages.

The medical society also endorsed "fluoridation of all drinking water systems in Hocking County, where feasible."

The physicians accepted an invitation for a joint dinner meeting with the Hocking County Bar Association, for a discussion of medical jurisprudence.

SCIOTO

Dr. William Havener, acting chairman of the Department of Ophthalmology, Ohio State University, Columbus, spoke on the subject, "Red Eye, Differential Diagnosis and Treatment," for the September 8 meeting of the Scioto County Medical Society in Portsmouth. A buffet supper was held following the 9:00 o'clock meeting in the Nurses Recreation Hall of General Hospital.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The following report is from the *Columbus Dispatch:*

Columbus Academy of Medicine announced it will sponsor a free health clinic for the citizens of Franklin County, March 18-22 in the Veterans Memorial.

Dr. Robert M. Inglis, academy president, said the exhibit, first of its kind, will be presented to provide the public a better insight on matters of health.

Each of the approximately 40 displays will be manned by a physician who will explain the exhibit and answer questions.

The exhibits will feature a series of scientific displays relating to newer concepts in the field of medicine and allied health professions. The academy will present authoritative and factual information in easily understood terminology.

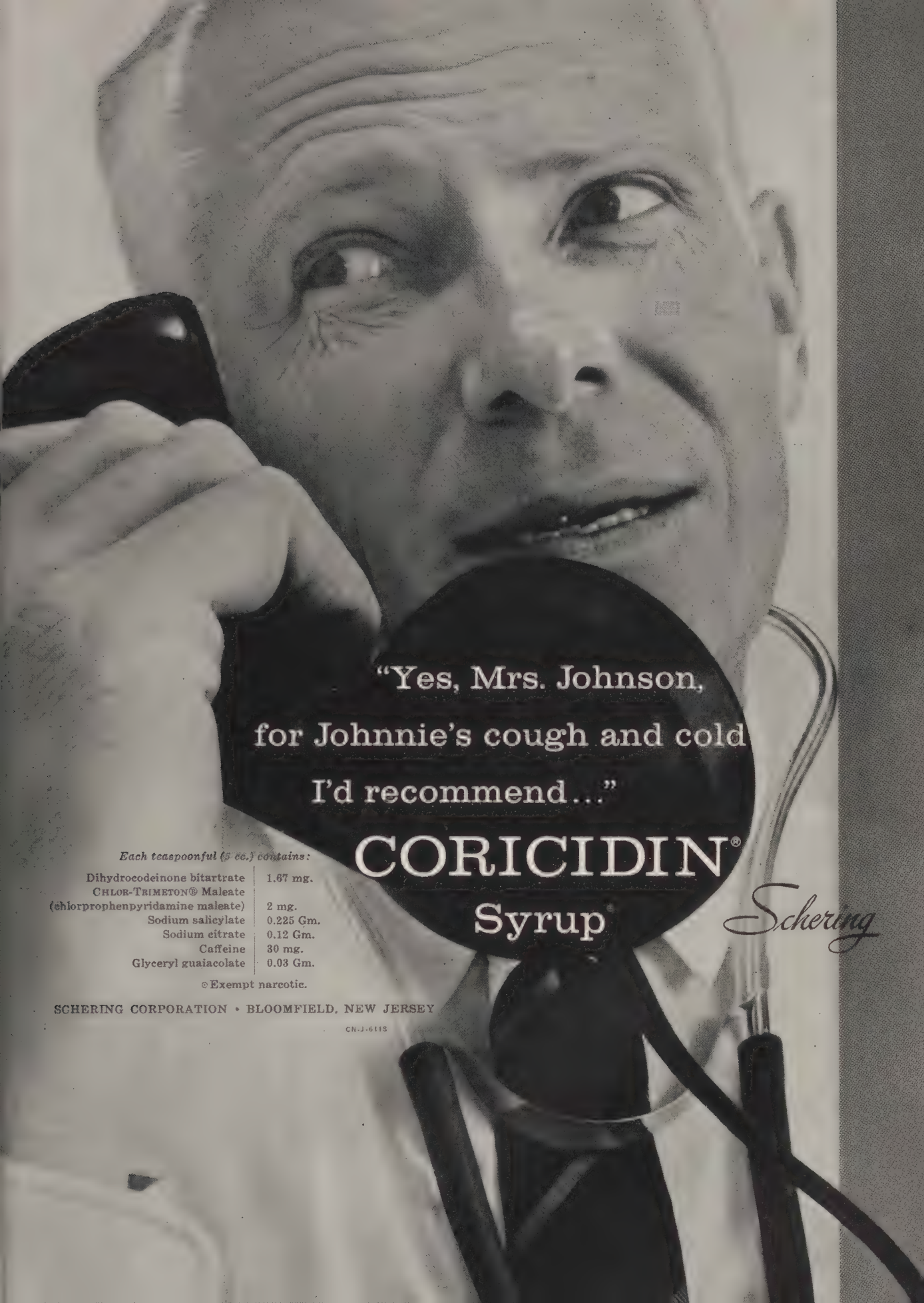
Guided tours will be conducted for school children, the academy announced.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ERIE

His experiences regarding motor vehicle accidents were discussed by Dr. Samuel Gerber,



Each teaspoonful (5 cc.) contains:

Dihydrocodeinone bitartrate	1.67 mg.
CHLOR-TRIMETON® Maleate (chlorprophenpyridamine maleate)	2 mg.
Sodium salicylate	0.225 Gm.
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Caffeine	30 mg.
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⊙Exempt narcotic.

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Cuyahoga County coroner, at the October 15 meeting of the Erie County Medical Society in Sandusky. Dr. Gerber also offered suggestions as to how fatalities may be lessened.

RICHLAND

The September meeting of the Richland County Medical Society was held at the Sky Club, with the doctors' wives as guests.

Other guests attending included Dr. H. T. Pease, Councilor of District No. 11, and Dr. M. D. Prugh, chairman of the State Organization of the American Medical Education Foundation.

After a very enjoyable dinner, a business meeting was held during which Doctor Prugh presented the official Award of Merit of the AMEF to Doctor Curtiss, President of the local Society, in recognition of the Society's special contributions to the AMEF.

After the business meeting, Dr. W. E. Wygant introduced the speaker of the evening, Mr. L. C. Mitchell, professor of art at Ohio University, Athens, Ohio, who presented a fascinating demonstration of water color drawing with a running accompaniment of dry humor, which was greatly enjoyed by all present.—John J. Clark, M. D., Secretary.

New Directory of U. S. and Canada Physicians Published by AMA

The United States and Canada have a population of more than 250,000 physicians.

These physicians are all listed in the new 20th edition of the American Medical Directory, published by the American Medical Association.

The Directory lists 250,621 physicians as compared to 240,638 in the 1956 edition.

Published as a service to physicians and the public, the directory lists for each physician his age, address, date of licensure, specialty, and membership in specialty medical groups.

The U. S. has 90,359 general practitioners in private practice and 77,655 specialists. There are 7,320 doctors in medical schools, research, and other work outside of private practice, and 17,303 holding full-time jobs on hospital staffs.

Other figures about the new directory are 18,398 new names; 1,214 names of physicians whose addresses are unknown, and 7,870 names have been deleted because of death.

Doctors are participating in the shifting national population, directory statistics show. Although New York still leads in the number of doctors—30,986—it also leads—with 360—those

(Continued on Page 1506)

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

MARCH 2, 3, 4, and 5, 1959

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist

Panels on Timely Topics **Teaching Demonstrations**

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Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

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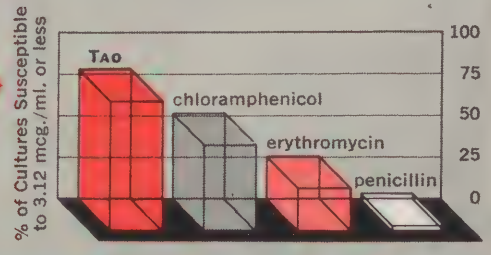
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

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stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

states showing losses of doctors since the last directory.

States with the biggest gains in physicians include: California, 1,040; Florida, 382; Michigan, 218; Ohio, 113; Arizona, 57; Oregon, 44, and Washington, 31.

Among those in the loss of column are Illinois, 318; Pennsylvania, 220; Minnesota, 159; Missouri, 150, and Iowa, 114.

When the first directory was published in 1906 it contained 128,173 names.

A copy may be obtained from the AMA office in Chicago at a cost of $35.00.

Credentials Deposit Service Is Offered by WMA

The following letter regarding a special service offered to physicians by the World Medical Association was received by the Ohio State Medical Association from Frank W. Barton, secretary, AMA Council on National Defense:

"The World Medical Association has initiated a program which the American Medical Association commends to your attention.

"On July 1, 1958, the services of a Central Repository for Medical Credentials became available to doctors of the world. During war and national uprisings, medical records are often lost or destroyed. Because of this, many doctors are today unable to utilize their professional skills because of the loss or destruction of their original credentials and a lack of a protective service in which authenticated copies could be deposited. Therefore, The World Medical Association has undertaken a program to assure that the doctor will always be able to prove himself medically trained and fully accredited to practice medicine.

"In the United States, the lifetime cost of the service on a one-payment basis to the newly graduated doctor is approximately $60.00. An actuarial schedule has been established for doctors in the various age groups. A 10-year service rate is also available.

"Repository officials suggest that the credentials deposited include official medical school record, medical diploma, and specialist credentials. American doctors should *not* send their original credentials, but should send photostatic, microfilm, or notarized copies of their original credentials.

"Requests for forms and additional information in regard to the Central Repository for Medical Credentials is available from The World Medical Association, 10 Columbus Circle, New York 19, New York."



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JOBBING STOCKS ALL LEADING MANUFACTURERS

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Prompt Service on Phone Orders



all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

...the prompt and prolonged activity of timed-release medication

Each* TUSSAGESIC *Tablet contains:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.;
pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-para-aminophenol)	325 mg.

Tussagesic Tablets provide relief from *all* cold symptoms in minutes, lasting for hours.

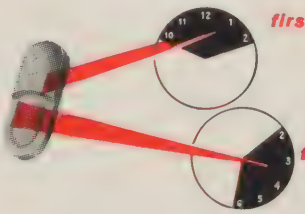
Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.

To reduce upper respiratory congestion and irritating secretions.

For non-narcotic control of the cough reflex.

To augment demulcent respiratory secretions.

For specific, highly effective antipyresis and analgesia.



first —3 to 4 hours of relief from the outer layer

then —3 to 4 more hours of relief from the inner core

Also available—for those who prefer palatable liquid medication—

Tussagesic suspension

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio
(See Page 1395 for roster of officers.)

CLARK

New members were honored and committee chairmen appointed at the first meeting of the year of the Clark County Auxiliary held in the home of Mrs. G. Robert Horton, Springfield. Fifty members were present.

Mrs. Lincoln Moore, Mrs. John Richsteiner, Mrs. Edwin Roberts, Mrs. Harold Shanklin, and Mrs. David Smith were welcomed as new members.

Mrs. W. H. Crays, president, appointed the following to serve as committee chairmen for the year: Attendance, Mrs. J. N. Hebble; Calling, Mrs. A. K. Howell; Civil Defense, Mrs. George A. Smith; Credits and Awards, Mrs. C. W. Hullinger; Finance, Mrs. W. J. Habeeb; Historian, Mrs. A. T. Anton; Hospitality, Mrs. D. H. Guyton; Legislation, Mrs. E. L. Ringer, Membership, Mrs. N. B. Pavlotos; Mental Health, Mrs. Max Graves, Mrs. Samuel Leber, co-chairman; AMEF, Mrs. J. F. Riesser; Nurse Recruitment, Mrs. J. A. Davidson; Parliamentarian, Mrs. E. P. Greenawalt; Philanthropy, Mrs. Charles E. Fralick; Program, Mrs. R. A. McLemore; Publicity, Mrs. Frank Anzinger, Jr.; Public Relations, Mrs. George P. Fitzgerald, Jr.; Scholarship, Mrs. E. W. Schilke; Safety and Rehabilitation, Mrs. G. F. Parker; *Today's Health,* Mrs. C. J. Townsend; Ways and Means, Mrs. H. E. Sanders, Mrs. R. B. Beam, co-chairman; Yearbook, Mrs. James Gianakopoulas; T. V., radio, and visual education, Mrs. J. W. Elliott.

Yearbooks prepared by Mrs. James Gianakopoulas were distributed. Mrs. Crays reported that Clark County had won first in the state among counties of its size for its sale of *Today's Health* and had won second place in the national contest for which the local Auxiliary received a cash prize of $25.

Mrs. Robert Beam, Mrs. Fralick and Mrs. Fitzgerald, Jr., were in charge of the tea which was served following the meeting. Mrs. Robert Arthur and Mrs. E. P. Greenawalt was the welcoming committee. Mrs. E. C. Nehls and Mrs. C. D. McIntire presided at the tea and coffee urns.

COLUMBIANA

The Woman's Auxiliary to the Columbiana County Medical Society held the first fall meeting, a luncheon, September 16, at the home of Mrs. Charles Gerace of East Liverpool.

Three State Officers were present, Mrs. Margaret Bauman, 6th District Director, of Warren, Mrs. Frances Thomas of Gorrettsville second vice-president, and Mrs. William J. Horger of E. Liverpool state publicity chairman.

Mrs. Bauman and Mrs. Thomas were presented money corsages. These were worn for a while and then the money was donated to the AMEF fund.

Mrs. William Banfield, president, presided.

Mrs. Charles Gerace gave out the year books and spoke briefly of the year's program. She then gave the theme for the year "Safe Guard To-Day's Health for To-Morrow."

Mrs. James Locke spoke on "Exploring the World of Gems."

Mrs. William Banfield and Mrs. William Horger were co-hostess.

CUYAHOGA

The Woman's Auxiliary to the Academy of Medicine of Cleveland has completed plans for its number one project—The American Medical Education Foundation.

A Christmas card designed by a doctor's son, Frank E. Bunts, is the means of the money making campaign. It is a discreet holiday card bearing the words, "Seasons Greetings," complete with the traditional holly wreath and the caduceus—the symbol of peace and healing.

Mrs. William A. Nosik is chairman of this project.

The Interstate Post Graduate Medical Association of North America, will have its annual meeting in Cleveland again this year. The Auxiliary members will man the Hospitality room at the Statler Hotel for three days, and be hostesses at a tea, luncheon and fashion show. Mrs. M. M. Perlich is hospitality chairman, and Mrs. T. T. Zuck co-chairman.

The Auxiliary will be represented by its president Mrs. F. Rittinger and others at the Public Health Committee meeting of the Cleveland Woman's City Club, and at the Community Chest and Red Cross meetings.

HAMILTON

The October meeting of the Woman's Auxiliary to the Academy of Medicine of Cincinnati was held Tuesday, October 21, at the Country Club. Following luncheon, the business meeting was presided over by Mrs. Earl C. Van Horn, president.

Dr. Esther Marting spoke on "Russian Medicine: Is It a Woman's World?"

Chairmen of the Day were Mrs. C. Wilke, pro-



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in the rheumatoid arthritic's shoes,
Doctor...

wouldn't you want a steroid
with a proved record
of safety and success?

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prednisone

you can count on rapid relief from pain, swelling and stiffness followed by functional improvement and maintained on an uncomplicated, low-dosage regimen **with minimal chance of side effects†** **and without unexplained weight loss, anorexia, muscle cramps** as reported with certain other corticoids†

†Round-table Discussion by Leading Investigators, San Francisco, Calif., June 20, 1958.

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gram chairman, and Mrs. E. H. Schweitzer, hospitality chairman.

KNOX

Activities for the fall and winter of the Woman's Auxiliary to the Knox County Medical Society were started with the meeting September 24 in the home of the president, Mrs. George Imhoff.

Mrs. C. E. Cassaday and Mrs. O. W. Rapp represented the Auxiliary at the Fall Conference September 8 in Columbus. Mrs. Julius Shamansky reported on the state meeting of the Golden Age club in Columbus September 22.

The secretary read a letter from the county nurses acknowledging the audiometer given for use in the county schools. They have screened 1,192 pupils to date.

The members voted a donation of $50 toward a folding machine for Golden Age bulletins and an invitation was received from the Columbus Academy of Medicine to meet with them on October 20.

MEDINA

The Woman's Auxiliary to the Medina County Medical Society entertained the Eleventh District of the Woman's Auxiliary to the Ohio State Medical Association on September 22, at a brunch at the Westfield Country Club. Mrs. John L. Jones of Medina is 11th District director.

Among the guests attending were State officers: Mrs. C. H. Bell of Mansfield, president; Mrs. C. A. Colombi of Cleveland, president-elect and Mrs. J. N. Wychgel of Shaker Heights, director of the 5th District.

A program was presented following the brunch. Included on the agenda was a one-act play on mental health education, entitled "Tomorrow is a Day," presented by the Medina Masquers, making up the Medina Society's part in the program.

Richland County Society presented a skit on Country Fair, which included an exhibition of nursing dolls, with a history of dolls, being given by Mrs. S. Lerro.

Erie County gave a report on their project with the AAPS essay contest and the Huron Society reported on their project in selling *Today's Health Magazine*."

Lorain County members discussed ways and means for raising money for Auxiliary projects.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met for luncheon at the Woman's Club on September 3. Thirty-Nine members were present.

In introducing Mrs. C. H. Bell, the State Auxiliary President, Mrs. Wain, local County President, urged all members to attend National and State meetings, if possible.

Mrs. Bell reported on the 35th Annual Wom-



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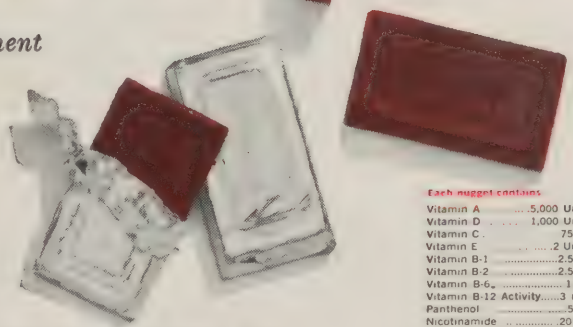
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Vitamin E	2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.2 mg.
Iodine	3.0 mg.
Magnesium	1.0 mg.
Manganese	1.0 mg.
Molybdenum	2.5 mg.
Potassium	

*U.S.P. Units †Int. Units

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an's Auxiliary to the AMA Convention, held June 22-26 in San Francisco.

Mrs. Bell called attention to the facts that there has been a gain in National membership of over 2000 members; three Ohio women are working on the National Board; Ohio won a top award for *Today's Health* subscriptions plus an award of merit for contributions to AMEF and that the Woman's Auxiliary is now incorporated and known as the National Auxiliary.

In calling for new business, Mrs. Wendell Bell stated that seven members of the Auxiliary had been approached by the Red Cross to assist in finding a chairman and committee heads for the Red Cross.

ROSS

Following a social hour with the Ross County Medical Society, September 6, at the home of Dr. R. L. Counts, the Woman's Auxiliary to the Society met for a business meeting and dessert at the home of Mrs. William Corzine, Jr.

Mrs. Robert Quinn presided and announced Mrs. J. C. Berno will be the new chairman of the magazine, *Today's Health*. She will be assisted by Mrs. Robert Swank. Mrs. R. E. Lightner reported on the nurses loan fund and stated that a loan had been made to a Kingston girl now entering training.

Mrs. Quinn stated that the group had sold 228 per cent of its magazine quota and was now rated as one of the most exclusive clubs. Mrs. Dow Scholl was chairman of the project during that time.

Mrs. William Garrett, mental health chairman, reported on the proposed mental health center to be located in Chillicothe.

Mrs. William Garrett, Mrs. Lourell Smith, Mrs. R. E. Lightner and Mrs. Robert Quinn represented the Auxiliary at the Fall Conference, September 8, in Columbus. Mrs. Walter Kramer, state safety chairman, also attended.

SCIOTO

The Woman's Auxiliary to the Scioto County Medical Society held its first fall meeting at the home of Mrs. William Hugenberg, Portsmouth, September 10.

The guest speaker was Dr. Raymond Carson whose subject was "Mental Health." He told of future plans for a "Guidance Center" in the area and the need of more volunteer service at the local Receiving hospital. The group was then entertained by Dr. Carson as a humorist and ventriloquist.

During the business meeting reports were given by eight members who recently attended the fourteenth annual conference of the woman's auxiliary to the Ohio State Medical Association at Columbus.

A social hour concluded the afternoon's meeting.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society held its Sixth annual hat parade and garden party on August 14, at the home of Dr. and Mrs. George T. Conger. This is the only fund raising project, the proceeds going to benefit the Nurses Revolving Loan Fund. This year the society had nine requests for loans. At present eight girls have made use of the funds, five at City Hospital, two at St. Thomas, and one at the University of Akron.

The Hobby Show for oldsters was held September 5, 6, and 8 in O'Neil's auditorium. Applicant must be 65 years of age or older and be able to show some handiwork he has done since his 65th birthday. There were approximately 138 exhibits this year, and it was said that these were the best ever displayed. This has been attributed to the keen competition which has developed among the hobbyists. A green ribbon is awarded to the most unusual exhibit. This year Mr. Clayton Schnabel earned this award with his unusual collection of dried seeds which were so neatly and interestingly displayed. Mrs. Mary Hurt, 90, and Mr. John Barnhart, 92, were again crowned queen and king, this honor going to the oldest hobbyists.

Several new booths were added this year to benefit the oldsters. The YMCA taught social bridge and cribbage. "The Art of Living for Senior Citizens" was directed to oldsters with no skills and therefore no hobbies. There was information, literature, guides, names of people and agencies who might help to direct these senior citizens to a new purpose in life.

As a result of last year's show, a year-round

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For Mentally Deficient Boys — Ages 3 to 15

Mrs. H. A. Copeland, Director



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or any rheumatic "itis"

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more potent and comprehensive treatment than salicylate alone

...assured anti-inflammatory effect of low-dosage corticosteroid[1]

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hobby center for oldsters has been set up in the Akron area. The auxiliary along with the United Community Council was instrumental in the organization of the Senior Citizens of Summit County, Inc. The oldsters had a building donated to them which they have named Krumroy Union No. 1. The building is a year-round center for socializing, practicing of crafts, classes, sales outlet, etc. Their membership has grown to approximately 200. On September 13, the oldsters held their first open house. The auxiliary furnished refreshments for this event.

The annual membership tea was held September 18, at the home of Dr. and Mrs. Arthur Dobkin. Approximately 30 new members attended and were welcomed at this time. Mrs. Edwin A. Riemendschmeider and her co-chairman Mrs. Anastasius H. Kyriakides were in charge of the arrangements and were assisted in the decorations by Mrs. Aris W. Franklin. Past-presidents presided at the tea table.

On October 7, the Woman's Auxiliary to the Summit County Medical Society met at the Smorgasbord in Stow. Betty Jaycox, woman's editor of the *Akron Beacon Journal,* spoke on "Personalities in the News." Following the program, President Mrs. Devitt L. Gordon presided at the business meeting.

TRUMBULL

Members of the Auxiliary to the Trumbull County Medical Society met with their husbands for dinner at the Squaw Creek Country Club on September 17. Congressman David Dennison addressed the combined group. Following the program, which had been arranged by the doctors, the Auxiliary held its regular business meeting.

The meeting was conducted by the president, Mrs. John Grima. Mrs. George Mokris called the members attention to the series of radio programs being sponsored by the Medical Auxiliary over the local station WHHH. They will be heard at 6:30 P. M. on the last Friday of each month. The first one was September 26, entitled "Over 35."

The Medical Auxiliary endorses two "Grey Ladies" activities for its members. They will continue to serve as nurses' aides at the Crippled Children's Clinic, and they will help two days out of each month at the Red Cross Blood Bank.

The Medical Society asked the Public Relations Committee of the Auxiliary to sponsor in the High School of Trumbull County, the essay contest promoted by the Association of American Physicians and Surgeons. The essays bear the title "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System."

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — WINTER 1958-1959

SURGERY—Surgical Technic, two weeks, Dec. 1, Feb. 2. Surgery of the Colon & Rectum, one week, Dec. 1, Mar. 2. Fractures & Traumatic Surgery, two weeks, Dec. 1. Treatment of Varicose Veins, two days, Dec. 15. American Board Review Course, two weeks, Apr. 6. Blood Vessel Surgery, one week, Mar. 2.

GYNECOLOGY & OBSTETRICS Office & Operative Gynecology, two weeks, Feb. 9. Vaginal Approach to Pelvic Surgery, one week, Nov. 17, Feb. 2. General & Surgical Obstetrics, two weeks, Feb. 23.

MEDICINE — Electrocardiography, two-week basic course, Mar. 16. Gastroscopy & Gastroenterology, two weeks, Mar. 2. Board Review Course, one week, Apr. 20.

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 1.

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"knee-itis"

there's pain
and inflammation here...
it could be mild or
severe, acute or chronic,
primary or secondary fibrositis
or even early
rheumatoid arthritis

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it calls for

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brings rapid pain relief; aids restoration of function

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Cleveland Office of the VA Announces Series of Clinical Conferences

The Cleveland Regional Office of the Veterans Administration has announced a series of clinical conferences which began in October and will continue through January 1959. The conference room is on the 7th floor of the Cuyahoga Building. Clinical conferences, with Dr. Charles Berns, as chairman, are scheduled on Wednesdays from 8:00 to 9:00 a. m. The following dates, subjects and speakers have been announced:

November 5—"Interesting Medical Cases"—Dr. S. Kessler.

November 12—"Some Ocular Manifestations of Systemic Diseases"—Dr. Nicholas J. Johnson.

November 19—"Social Service in Cleveland Regional Office"—Mr. F. P. Straub.

December 3—"Clinical Pathological Conference" —Dr. F. Bayless.

December 10 — "Facial Plastics" — Dr. J. G. Himmel.

December 17—"Recent Advances in Heart Disease"—Dr. J. B. Tuckerman.

January 7, 1959—"Cancer of the Cervix"—Dr. R. E. Bowman.

January 14—"Rating Board Medical Problems"—Rating Board Doctors.

January 21—"Carcinoma of Prostate—Diagnosis and Treatment"—Dr. Harry Trattner.

January 28—"VA Research on Psychotherapy and Tranquilizers"—Dr. H. S. Curtis and Dr. M. S. Slobin.

Ft. Steuben Academy

"Consideration of Some Diffuse Pulmonary Fibroses," was the topic discussed at the October 14 meeting of the Fort Steuben Academy of Medecine in Steubenville. Speakers were Dr. Elliot Lasser, professor of radiology at the University of Pittsburgh, and Dr. David Greenberg, radiologist at the Ohio Valley Hospital, Steubenville.

The number of orphans has dropped from 6.4 million in 1920 to 2.7 million in 1958, says Health Information Foundation. Yet the child population has risen from 39 to 60 million in that time.

A typical child born today has 25 chances in 1,000 of losing his mother by death before he reaches 18 and 57 chances in 1,000 of losing his father. Fewer than one out of every thousand children in the country nowadays has lost both parents.—*Health Information Foundation.*



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Three Organizations List Films Available

Three developments in the medical motion picture field are of interest to Ohio physicians. First is the announcement that "MD International," a color film on work of American doctors abroad produced by Smith, Kline and French Laboratories in cooperation with the AMA, is available on a loan basis. Physicians may obtain the film on loan without charge by writing to Smith, Kline and French Medical Film Center, 1500 Spring Garden Street, Philadelphia 1, Pa.

Second, "Reach for Tomorrow," a documentary film of five human experiences along the road to rehabilitation narrated by Henry Fonda, may be rented for $3.50 plus postage from the National Society for Crippled Children and Adults, Inc., 11 South LaSalle Street, Chicago 3, Illinois.

Third, the Ohio Division of Mental Hygiene, State Office Building, Columbus, has published a list of sound films available for adult use only. The list contains films for general adult viewing, parents, teachers, and physicians and other professional persons.

Physicians also will find of interest the film "San Francisco—1958." This 30-minute production features summaries of the AMA's 1958 annual meeting by five of the top physician-speakers on the program.

Life Insurance Fund Promotes Many Heart Research Projects

Over 100 research programs devoted to heart disease were supported during 1958 by the Life Insurance Medical Research Fund, according to the fund's annual report. Over $1,086,000 has been allocated to continue this support. The fund is supported by 144 life insurance companies. Its resources are devoted entirely to heart research. Since the fund's organization in 1945, over $10,300,000 has been contributed to this vital work.

Industrial Nursing

A concentrated course in Industrial Health for registered nurses only is offered for the fifth consecutive year by the Institute of Industrial Health of the University of Cincinnati during the week of March 2nd, 1958. The faculty, under the Directorship of Dr. Robert Kehoe, will include the staff of the Institute and selected guest instructors.



NEW! TARCORTIN LOTION
excellent for lesions of head and hands
SUPPLIED: plastic squeeze bottles, ½ oz.

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Write for additional information regarding other uses which include management of hiccup and reflex vomiting, as well as relief of discomfort associated with laryngoscopy, esophagoscopy, gastroscopy and the passage of esophageal and gastric tubes.

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both are often needed when
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Mysteclin-V contains tetracycline phosphate complex

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It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications

Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against Candida (Monilia) albicans.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Capsules *(250 mg./250,000 u.), bottles of 16 and 100.* Half-strength Capsules *(125 mg./125,000 u.), bottles of 16 and 100.* Suspension *(125 mg./125,000 u. per 5 cc.) 60 cc. bottles.* Pediatric Drops *(100 mg./100,000 u. per cc.). 10 cc. dropper bottles.*

SQUIBB *Squibb Quality — the Priceless Ingredient*

'MYSTECLIN'®, 'SUMYCIN'®, AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

Pyribenzamine® EXPECTORANT breaks up cough

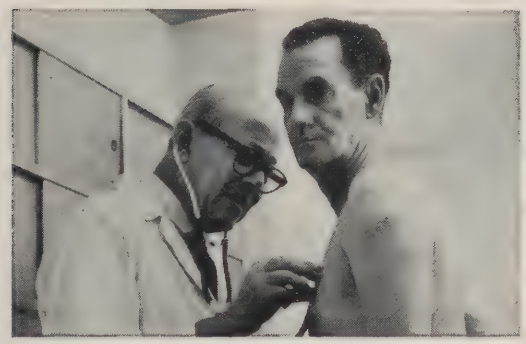
even persistent cough



Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief—a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine*, containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon.

Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine*, same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

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Pyribenzamine® citrate (tripelennamine citrate CIBA) 2/2559MK SUMMIT, N. J.

in all
diarrheas

CREMOMYCIN®

SUCCINYLSULFATHIAZOLE—NEOMYCIN SUSPENSION WITH PECTIN & KAOLIN

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MORE THAN
16 MILLION DOSES
ADMINISTERED WITH
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regardless of
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For dietary management of serum cholesterol...

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...a natural food and the only readily available vegetable oil made from golden corn

...rich in important unsaturated fatty acids, contains 56% linoleic acid



EASY AND PLEASANT TO ADMINISTER

Mazola Corn Oil, a highly palatable natural food, can easily be included as part of the everyday meals...simply and without seriously disturbing the patient's usual eating habits.

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Extensive recent clinical findings now show that serum cholesterol levels tend to be lower when an adequate amount of Mazola Corn Oil is part of the daily meals... high levels are lowered...normal levels remain normal.

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Nutrition authorities commonly recommend that from one-third to one-half of the total fat intake should be of the unsaturated type, whenever serum cholesterol control is a problem. The high content of important unsaturated fatty acids in Mazola, plus its other desirable characteristics, make it the oil of choice.

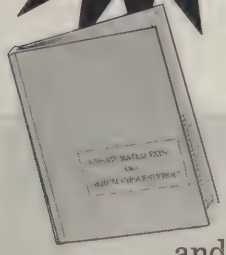
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Provides approximately:

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Unsaturated Fatty acids	85% of total

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MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

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multiple compressed tablets

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THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



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MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation...

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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.



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GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.

ORAL SUSPENSION
(orange-flavored)
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Proven in research

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And now in practice

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antibacterial plus added protection against monilial superinfection

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For relief of symptoms and malaise of the common cold and prevention of secondary complications

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REFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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*Trademark

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A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:

1 or 2 tablets.

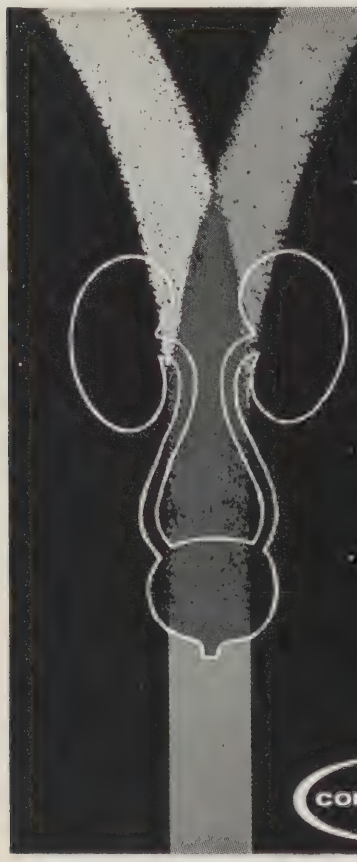
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...IN URINARY COMPLAINTS

* Sterilizes urine in 1 to 3 days
* Relieves burning in minutes
* Effective in 93-98% of cases

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The original Azo-Sulfa Formula* • Antibacterial • Analgesic

LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl—acts solely on the urogenital mucosa; provides prompt relief from burning, pain and frequency.

LOCALIZED ANTIBACTERIAL ACTIVITY

Sulfacetamide—eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.

...and when Spasmolysis is essential

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Antibacterial • Analgesic • Antispasmodic

—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

*Introduced—July, 1954

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Symptomatic

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. . . plus!

Achrocidin*

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE



pneumonitis

adenitis

sinusitis

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COMBINES: Traditional components for relief of the annoying symptoms of early upper respiratory infections...

PLUS: Protection against bacterial complications often associated with such conditions.

TABLETS (sugar coated)
Each contains:

ACHROMYCIN* Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP (lemon-lime flavored, caffeine-free)
Each 5 cc. teaspoonful contains:

ACHROMYCIN* Tetracycline equivalent to Tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 fl. oz.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children adjusted according to age and weight.
Available on prescription only.

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"Premarin" with Meprobamate new potency

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For undue emotional stress in the menopause

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Also available as PMB-400 (0.4 mg. "Premarin," 400 mg. meprobamate in each tablet).

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No. 880, PMB-200 bottles of 60 and 500.
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both cause and fear of
ANGINA ATTACKS

proven safety for long-term use



Miltrate*

NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with **MILTOWN®** The *original* meprobamate, discovered and introduced by Wallace Laboratories

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sustained coronary vasodilation with **PETN** pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate,"...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 18D

1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

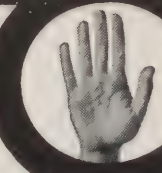
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now—an antibiotic troche that

STOPS COUGH TOO





The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

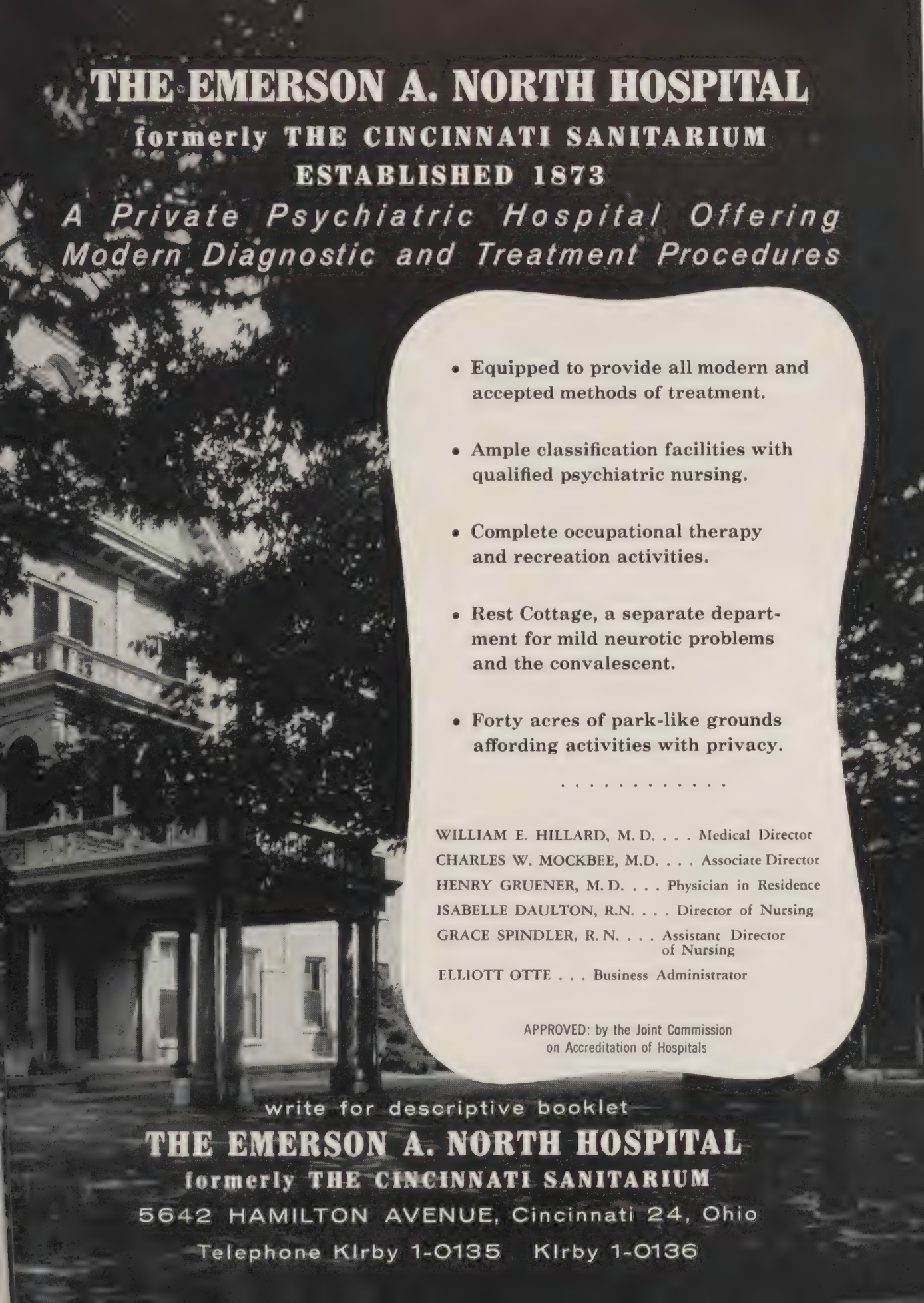
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Pentazets®

antitussive—antibiotic—anesthetic—analgesic troches

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DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Dosage: Three to 5 troches daily for 3 to 5 days.
Supplied: In vials of 12.
PENTAZETS is a trademark of Merck & Co., Inc.



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formerly THE CINCINNATI SANITARIUM

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A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
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Steel Union Studies Plans for Hospitals and Clinics

The following special article appeared in the *New York Times* under an Atlantic City dateline on September 19:

"The United Steelworkers of America took the first step toward setting up its own chain of hospitals and medical centers to meet the health needs of its 1,250,000 members.

"The move reflected mounting labor dissatisfaction with Blue Cross and other programs approved by organized medicine. The steel union asserted that its members were not receiving adequate protection in return for the $134,224,000 a year now being paid for health insurance under plans jointly financed by the steel companies and the workers.

"The closing session of the union's biennial convention unanimously approved an investigation into the practicability of establishing facilities to provide complete health care for the members and their families through collective bargaining.

"In addition to hospitals, such a program would include clinics, diagnostic centers, rest homes, rehabilitation centers, nursing homes and "fully pre-paid medical care plans utilizing group practice medicine." The only union that now has a program embracing any substantial part of this objective is the United Mine Workers.

"The steel convention directed that a new effort be made in next year's contract negotiations to force the companies to pay the full cost of life and health insurance and other medical programs. Under the present 50-50 sharing of the insurance bill, the average steel worker pays $9.50 a month for insurance. A shift would add $100,000,000 a year to the industry's labor costs."

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

American Association of Blood Banks, Netherland-Hilton Hotel, Cincinnati, November 20-22.

Central Ohio Heart Association, Scientific Council Session, Columbus, November 5.

Franklin County Academy of General Practice, Fall Seminar, Columbus, November 21.

Interstate Postgraduate Medical Association, 43 International Medical Assembly, Cleveland, November 10-13.

Southwestern Ohio Society of General Physicians, University of Cincinnati, Series of Courses on Radiology, Tuesdays, as announced.

Veterans Administration, Series of Clinical Conferences, Cleveland, Wednesday Evenings.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

MEDICAL AND DENTAL OFFICES available in a new ten-unit all airconditioned medical building. Contact A. W. Brownstone, M. D., Painesville, Ohio.

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OB-GYN, BOARD QUALIFIED, Graduate Milan, Italy, 1951; residencies Margaret Hague Maternity Hospital and Beth Israel Hospital, N. J.; Ohio licensed; married; wishes to join group or associate with established Ob-Gyn leading to partnership. Box 110, c/o Ohio State Medical Journal.

OFFICE SUITE FOR RENT: Main thoroughfare in Toledo, Ohio; 3 rooms plus bathroom and laboratory in busy General Practitioner's Bldg. Ideal for Ophthalmologist, Dentist or Dermatologist. Air conditioned, gas heat. Very reasonable rent. Box 108 c/o Ohio State Medical Journal.

FOR SALE: EENT equipment including instruments, instrument cabinets, autoclave, suction and irrigation pumps, Cameron Cautery, National Cautery and trans-illuminator. Box 111, c/o Ohio State Medical Journal.

WANTED: General Practitioner, town of 1700 population, hospital facilities and office space available. Good community in which to work. Contact: Plymouth Chamber of Commerce, c/o Rev. R. F. Hall, 45 W. Broadway, Plymouth, Ohio.

ENT and/or EYE MAN, Solon, Ohio; offices available in new medical bldg., with established surgeon and internist. Contact E. C. Svec, M. D., 32750 Solon Rd., Solon, Ohio, or Phone CH 8-6085.

FOR SALE: Profexray-Portable in perfect condition. Very reasonable. Box 109, c/o Ohio State Medical Journal.

OFFICE SPACE AVAILABLE for lease; five 20x60 ft. rooms at 3238 Cleveland Ave., Columbus. Call Martin J. Ryan Co., CA 4-5300.

Army Medical Department Releases Book on Cold Injuries

Another in the series of volumes published by the Medical Department of the U. S. Army detailing medical treatment during World War II is now on the market.

The book entitled *Cold Injury, Ground Type, in World War II,* is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., at $6.25. Authors are Colonel T. F. Whayne, MC, USA (Ret), professor of preventive medicine, University of Pennsylvania; and Michael E. DeBakey, M. D., professor of surgery and chairman of the Department, Baylor University College of Medicine.

Experiences with cold injuries is treated in the form of a medical text with ample illustrations in color and black and white.

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HIGHLY EFFECTIVE AGAINST STAPHYLOCOCCI..

CHLOROMYCETIN®

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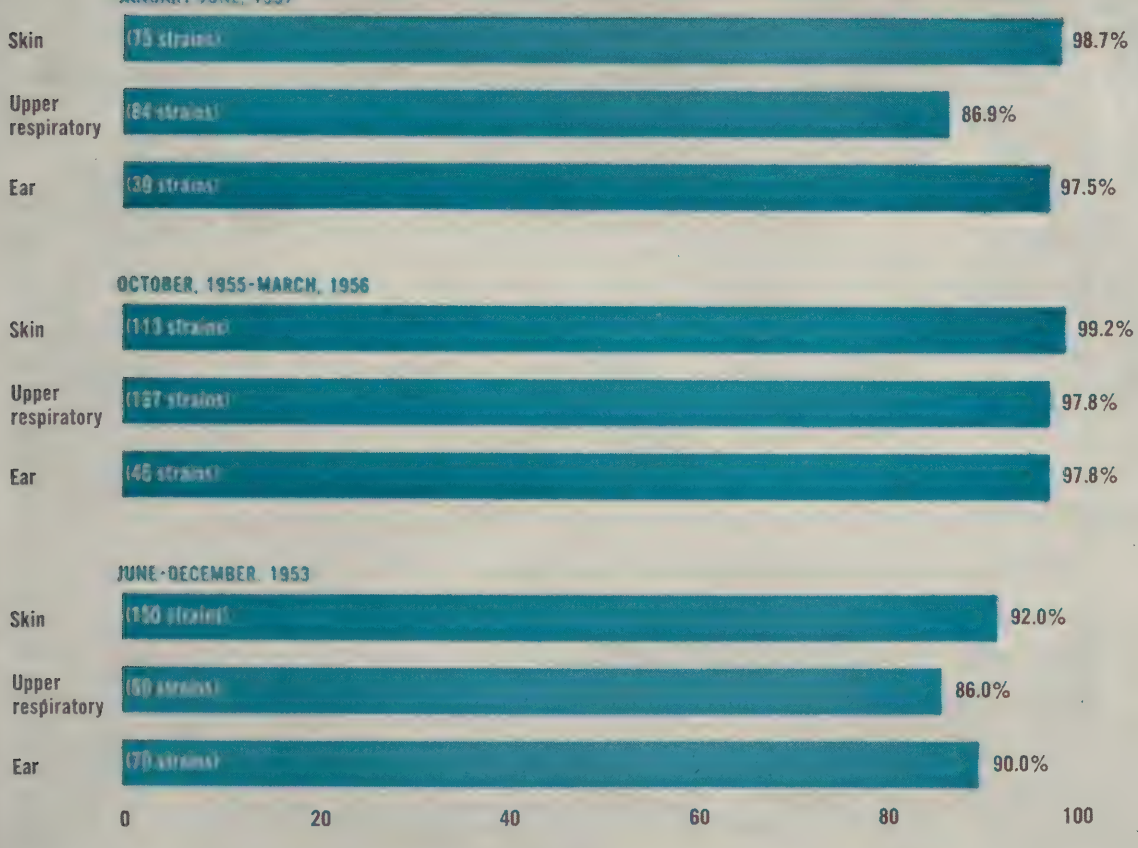
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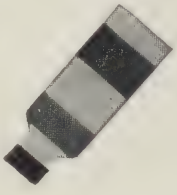
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Vol. 54 December, 1958 No. 12

Published monthly by The Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio. Subscription, $5.00 per year to non-members; Single Copy, 50 cents.

Entered as second class matter July 5, 1905, at the Postoffice at Columbus, Ohio, under the Act of Congress of March 3, 1879; Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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CUYAHOGA—Chester R. Jablonoski, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 4. 3rd Tuesday monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

SEVENTH DISTRICT

BELMONT—David Danenberg, President, Bridgeport; Bertha M. Joseph, Secretary, Martins Ferry. 3rd Thursday, monthly.

CARROLL—Joseph D. Stires, President, Malvern; Samuel L. Weir, Secretary, Minerva. 1st Thursday, monthly.

COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vormes, Secretary, Scio. Meetings quarterly.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Snaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Rocne, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

ATHENS—Don R. Johnson, President, Nelsonville; Charles R. Hoskins, Secretary, Athens. 2nd Tuesday, monthly.

FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

WASHINGTON—Richard R. Hille, President, Marietta; Roy M. Meredith, Secretary, Marietta. 2nd Wednesday, monthly.

NINTH DISTRICT

GALLIA—Ralph B. Burner, President, Gallipolis; George E. Files, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Robert M. Andre, President, Waverly; Mack E. Moore, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. Second Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

DELAWARE—Mary K. Kuhn, President, Ashley; Edward C. Jenkins, Secretary, Delaware. 3rd Tuesday, monthly.

FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, London; Paul G. H. Wolber, Secretary, London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Harold V. Marley, President, Ashland; Myron A. Shilling, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—Owen J. Nicholson, President, Norwalk; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria; Mrs. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Charles F. Curtiss, President, Bellville; John J. Clark, Secretary, Mansfield.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.

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The best hope of saving lives from cancer is early detection and prompt, proper treatment. Progress in the last ten years has already raised this life-saving rate from 1 in 4 to 1 in 3 as more and more people go to their doctors **in time.**

But with present knowledge it is possible **today** to save 1 in 2 cancer patients. Our two integrated programs are directed to meeting this challenge.

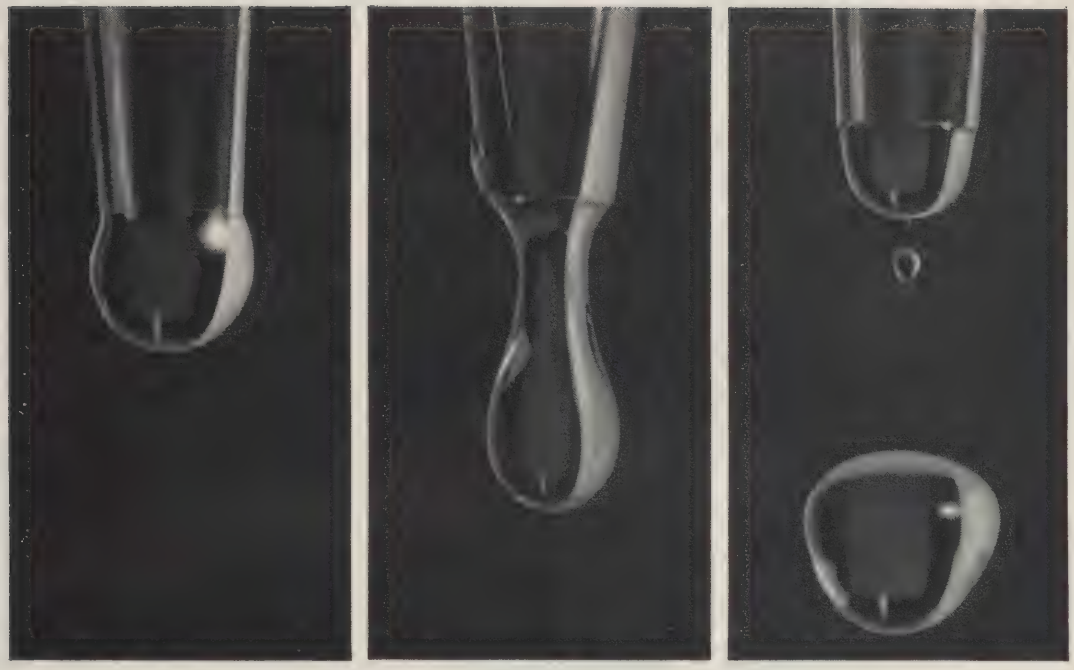
Our professional education program offers doctors a variety of free services: literature... films... exhibits... slides, and other materials on latest advances in therapy and research.

Our public education program urges people to see their doctors at the first sign of a danger signal, and to have annual health checkups no matter how well they may feel.

The challenge will be met. As more and more doctors' offices become "cancer detection centers," and as more and more people see their doctors regularly, the closer will come the day when half of our cancer patients will be saved. The know-how for saving the remaining half is still being sought in research laboratories. Ultimately, that challenge, too, will be met.

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ZANCHOL®

Improves Flow and Color of Bile

Zanchol (brand of florantyrone), a distinct chemical entity unrelated to the bile salts, provides the medical profession with a new and potent hydrocholeretic for treating disorders of the biliary tract.

The high degree of therapeutic activity of this new compound and its negligible side reactions yield distinct clinical advantages.

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Bile with these qualities minimizes biliary stasis, reduces sediment and debris in the bile ducts and discourages the ascent of infection.

For these reasons ZANCHOL has shown itself to be a highly valuable agent in chronic cholecystitis, cholangitis and care of patients following cholecystectomy.

Administration: One tablet three or four times a day. Zanchol is supplied in tablets of 250 mg. each. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

Faster rehabilitation in

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

a

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .



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Rheumatoid Arthritis

multiple compressed tablets

MEPROLONE®

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .



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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

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CLINICAL BRIEFS FOR MODERN PRACTICE



if your patient wears tinted glasses and sighs frequently...?

She may have an anxiety state. The tinted glasses may be worn as a shield against the world—and to relieve the photophobia resulting from pupillary dilatation caused by anxiety-induced hyperadrenalism. The sighs may be a result of fatigue from emotional unrest.

Source—Meyer, O. O.: Northwest Med. *53*:1006, 1954.

*4 findings from a recent study**

calmative **nostyn**® Ectylurea, AMES (2-ethyl-*cis*-crotonylurea)

1. Anxiety and nervous tension appeared to be most benefited by NOSTYN.
2. Seventy per cent of patients obtained some degree of relief.
3. Greater inward security and serenity were experienced and expressed.
4. Mental depression did not develop in patients previously depressed by meprobamate or a similar drug.

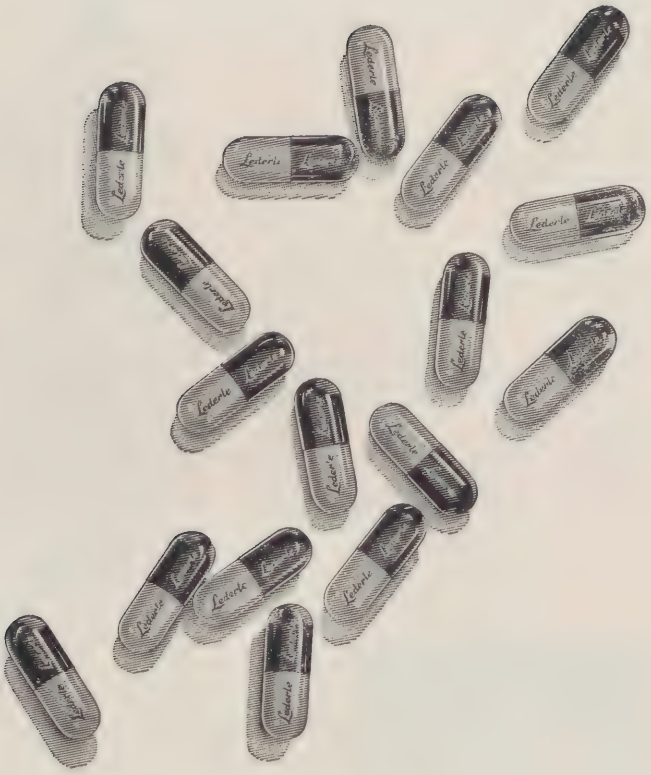
dosage: 150-300 mg. (½ or 1 tablet) three or four times daily. *supplied:* NOSTYN tablets, 300 mg., scored. Bottles of 48 and 500.

*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: New York J. Med. *58*:520 (Feb. 15) 1958.

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FAST-ACTING ORAL BROAD-SPECTRUM THERAPY. The modern blue and yellow ACHROMYCIN V Capsules, combining equal parts of pure crystalline ACHROMYCIN Tetracycline HCl and Citric Acid, provide unsurpassed oral broad-spectrum therapy.

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ACHROMYCIN V dosage; Recommended basic oral dosage is 6-7 mg. per lb. body weight per day. In acute, severe infections often encountered in infants and children, the dose should be 12 mg. per lb. body weight per day. Dosage in the average adult should be 1 Gm. divided into four 250 mg. doses.

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Tetracycline HCl and Citric Acid Lederle

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Mazola® Corn Oil...a palatable food effective in the management and control of serum cholesterol levels

Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal . . . high blood cholesterol levels are lowered, normal levels maintained.

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Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

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Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

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Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

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Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

CORN PRODUCTS
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MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg.

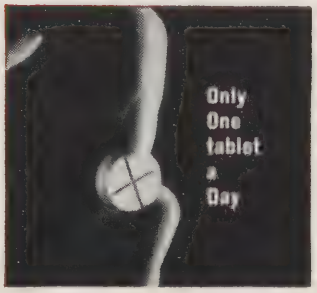
TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

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Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle



Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

*Reg. U. S. Pat. Off.

The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

So You Want To Be A Doctor, by Alan E. Nourse, M. D. ($2.75, *Harper & Brothers, New York 16, New York.)*

The Chemistry of Organic Medicinal Products, by Glenn L. Jenkins, W. H. Hartung, K. E. Hamlin and J. B. Data. ($10.75, Fourth Edition, *John Wiley & Sons, Inc., New York 16, N. Y.)*

Management of Endocrine Problems, by Allan C. Barnes, M. D. ($18.00, Four Volumes, *Harper & Brothers, New York 16, New York.)*

Modern Clinical Psychiatry, by Arthur P. Noyes, M. D., and L. C. Kolb, M. D. ($8.00, Fifth edition, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Orr's Operations of General Surgery, by George A. Higgins, M. D., and Thomas G. Orr, Jr., M. D. ($20.00, Third edition, *W. B. Saunders Company, Philadelphia 5, Pa.)*

The Cerebrospinal Fluid; Production, Circulation and Absorption. A Ciba Symposium, by G. E. W. Wolstenholme and Cecilia M. O'Conner. ($9.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

Laboratory Medicine — Hematology, by John B. Miale, M. D. ($13.75, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

Health Yearbook: 1957, compiled by O. E. Byrd, M. D. ($5.50, *Stanford University Press, Stanford, California.)*

Modern Marriage and Family Living, by Morris Fishbein, M. D., and Ruby J. R. Kennedy, Ph. D. ($5.00, *Oxford University Press, New York 11, New York.)*

A Primer for Coronary Patients, by Robert J. Needles, M. D., and Edith M. Stoney. ($3.75, *Appleton-Century-Crofts Co., Inc., New York 1, New York.)*

Diseases of the Thyroid and Parathyroid Glands, by B. J. Ficarra, M. D. ($8.50, *Intercontinental Medical Book Corporation, New York 16, New York.)*

Orthopedic Diseases: Physiology, Pathology and Radiology, by Ernest Aegerter, M. D., and John A. Kirkpatrick, Jr., M. D. ($12.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Tuberculosis in White and Negro Children: The Epidemiologic Aspects of the Harriet Lane Study; Volumes I & II. Vol. I by Janet B. Hardy, M. D., and Vol. II by Miriam E. Brailey, M. D. ($12.00 (Two Volumes), Published for The Commonwealth Fund by *Harvard University Press, Cambridge 38, Mass.)*

Medical Electrical Equipment, by Robert E. Molloy with nineteen contributors. ($15.00, *Philosophical Library, Inc., New York 16, New York.)*

Theory of Psychoanalytic Technique, by Karl Menninger, M. D. ($4.75, *Basic Books, Inc., New York 3, New York.)*

Fundamentals in Cardiology, by John B. Wild, M. D. ($4.50, *Charles C. Thomas Publisher, Springfield, Illinois.)*

Year Book of Dermatology and Syphilology 1957-1958 Series, by Rudolf L. Baer, M. D., and Victor H. Witten, M. D. ($8.00, *Year Book Publishers, Inc., Chicago 11, Illinois.)*

Fifty Years of Neurosurgery: A Personal Story, by Ernest Sachs, M. D. ($3.50, *Vantage Press, Inc., New York 1, New York.)*

Selected Writings of John Hughlings Jackson: Volume I, by James Taylor, M. D. ($15.00 (Two Volumes), *Basic Books, Inc., New York 3, New York.)*

Etiology and Treatment of Leukemia, by Walter J. Burdette, M. D. ($4.00, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

Polyscience, by Frank H. Kelly, M. D. ($2.95, *Vantage Press, New York 1, New York.)*

Clinical Orthopaedics: No. 11, by Anthony F. DePalma, M. D. ($7.50, single copy, $12.00, two volumes, *J. B. Lippincott Company, Philadelphia 5, Pa.)*

Hormone Production in Endocrine Tumours: Volume 12, by G. E. W. Wolstenholme and Maeve O'Connor. ($9.00, *Little, Brown & Company, Boston 6, Massachusetts.)*

How To Live With Diabetes, by Henry Dolger, M. D., and Bernard Seeman. ($3.50, *W. W. Norton & Company, Inc., New York 3, N. Y.)*

General Pathology, by Sir Howard Florey. ($16.00, Second edition, *W. B. Saunders Company, Philadelphia 5, Pa.)*

The Esophagus; Medical and Surgical Management, by Edward B. Benedict, M. D., and George L. Nardi, M. D. ($15.00, *Little, Brown & Company, Boston 6, Mass.)*

Pyribenzamine® EXPECTORANT breaks up cough

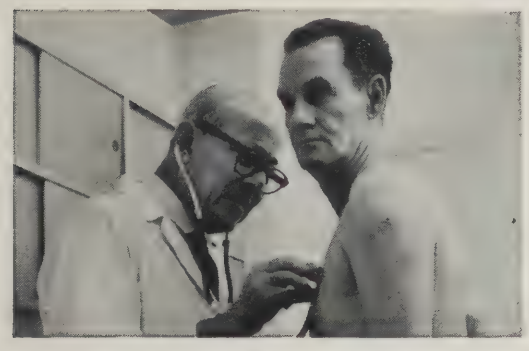
even persistent cough



Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief—a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine*, containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon.

Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine*, same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

CIBA
SUMMIT, N. J.

Pyribenzamine® citrate (tripelennamine citrate CIBA) 2/2559MK



Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
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for
the control
of all
coccal
infections

abbott's antibiotic triad



Erythrocin®

stearate

(Erythromycin Stearate, Abbott)



indications:

In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

dosage:

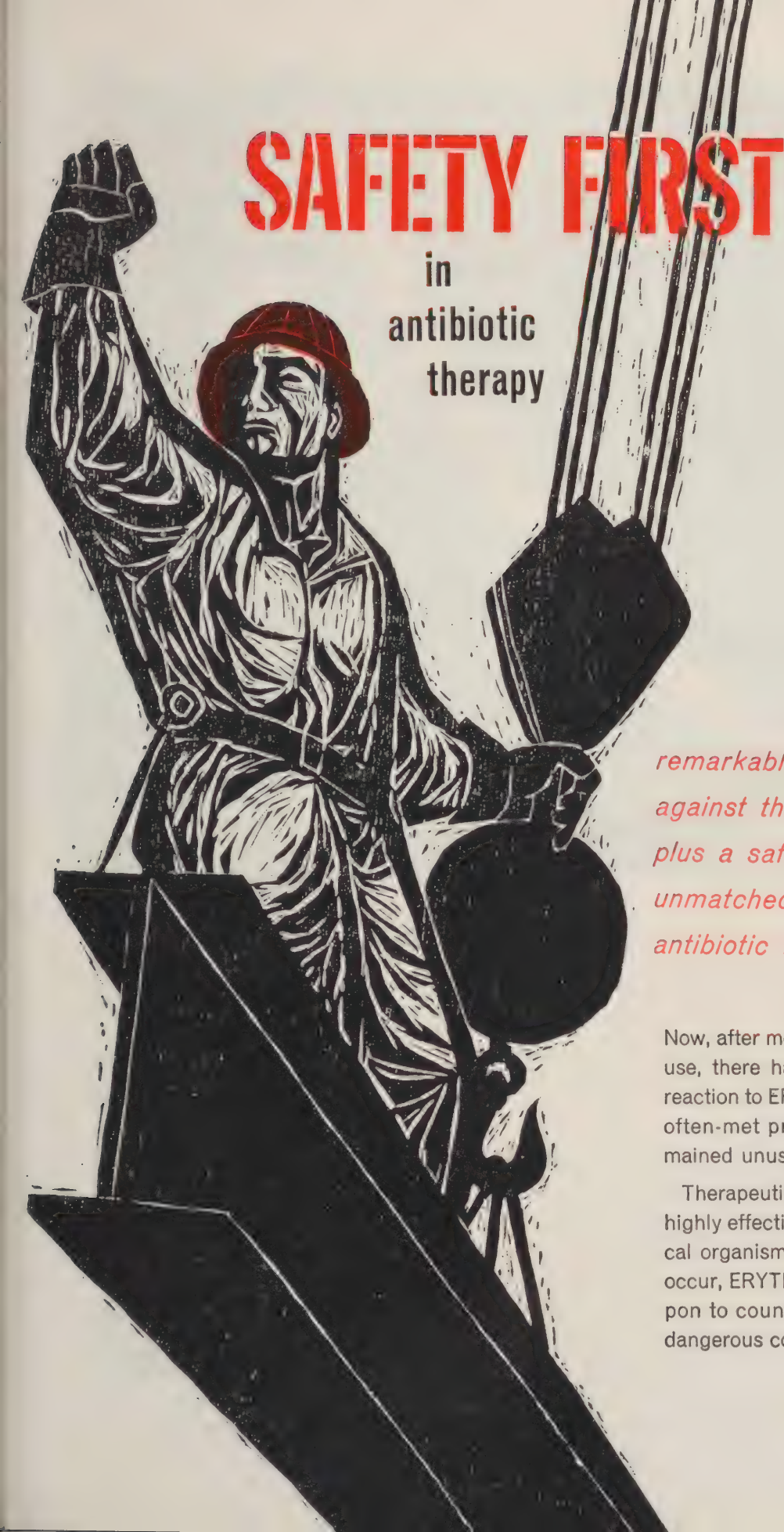
Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

supplied:

In bottles of 25 and 100 Filmtabs (representing 100 and 250 mg. of ERYTHROCIN activity). Also, in cinnamon-flavored oral suspension; 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

® Filmtab — Film-sealed tablets, Abbott; pat. applied for.

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SAFETY FIRST

in antibiotic therapy

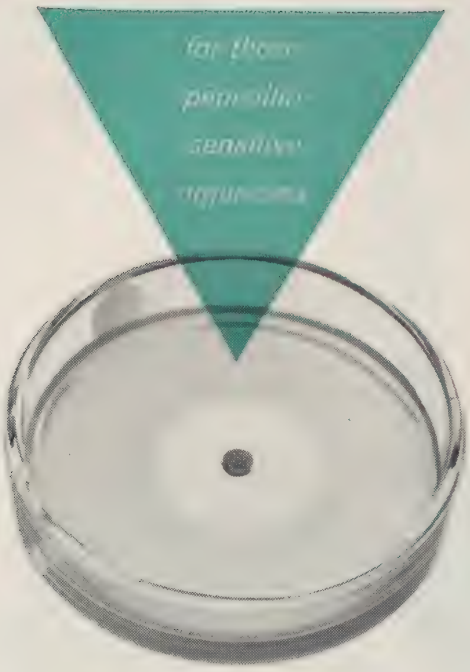
remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

Abbott

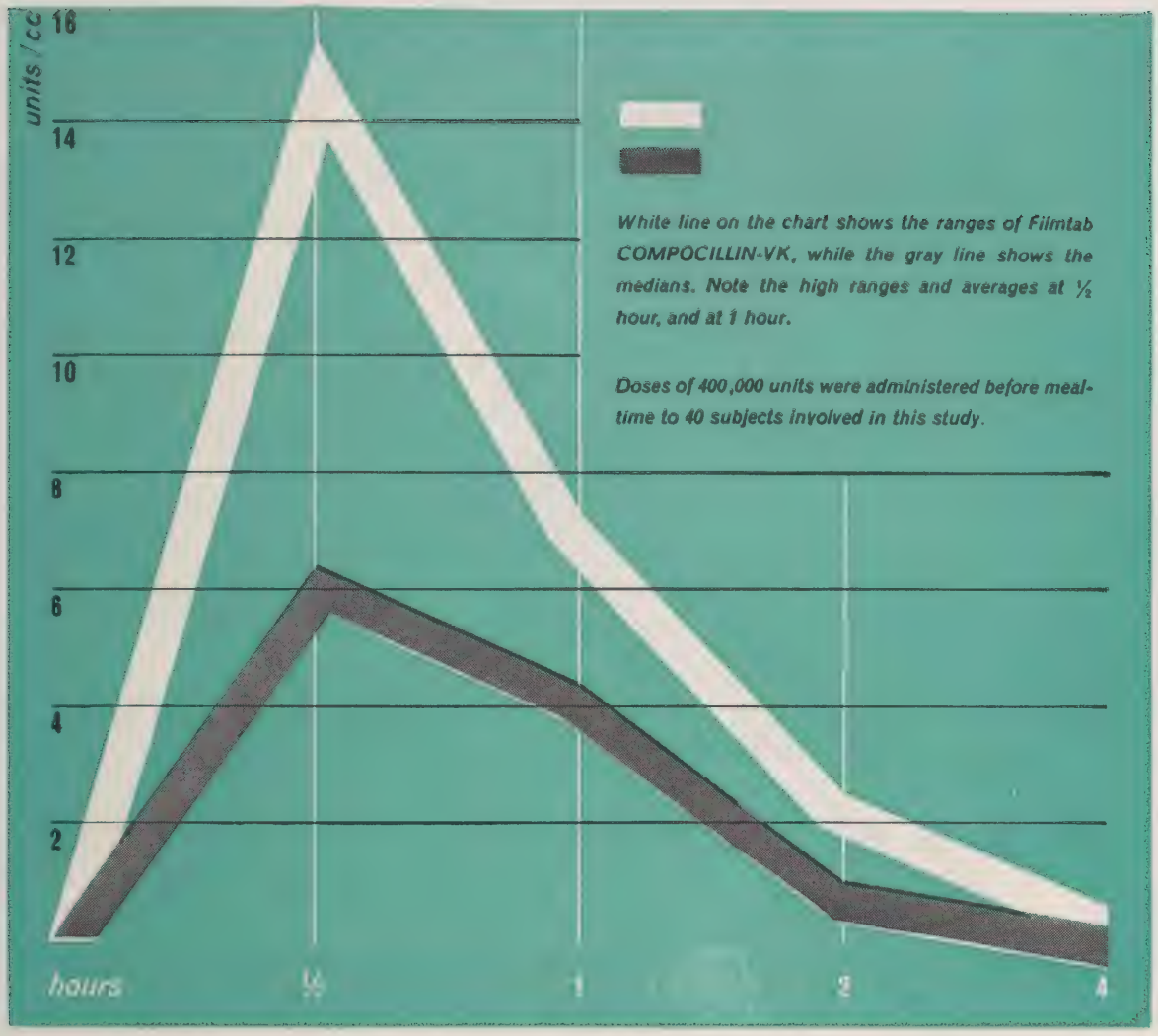
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the higher blood levels of COMPOCILLIN-VK

Potassium
Penicillin V

809136



Now, in both Filmtab and Oral Solution, patients get high penicillin V blood levels with Compocillin-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

Compocillin-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, Compocillin-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

Compocillin-V® Oral Suspension (Ready-Mixed), Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. Abbott



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Toxicity? Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report[3] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

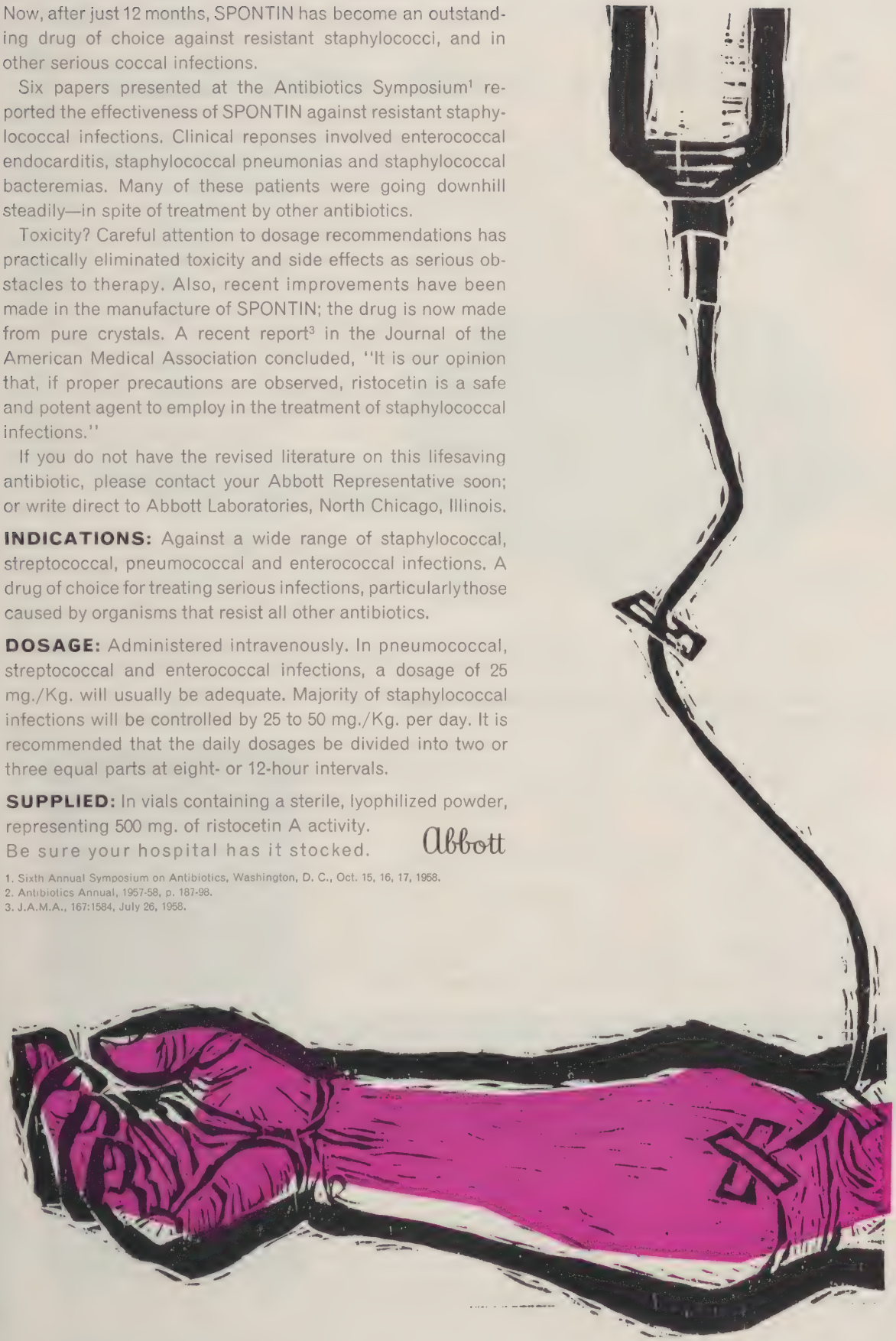
If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

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DOSAGE: Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

SUPPLIED: In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.
Be sure your hospital has it stocked. Abbott

1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
2. Antibiotics Annual, 1957-58, p. 187-98.
3. J.A.M.A., 167:1584, July 26, 1958.



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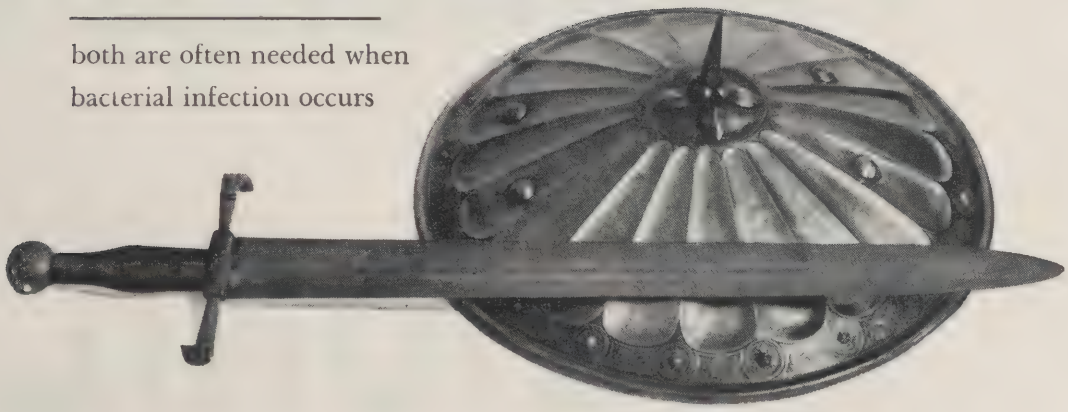
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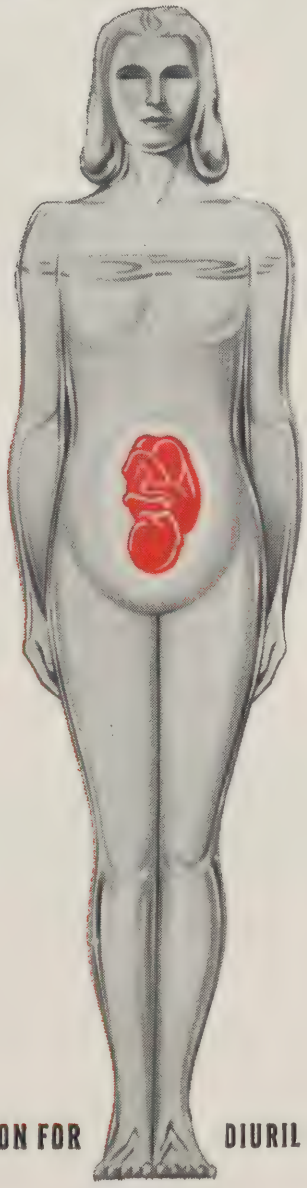
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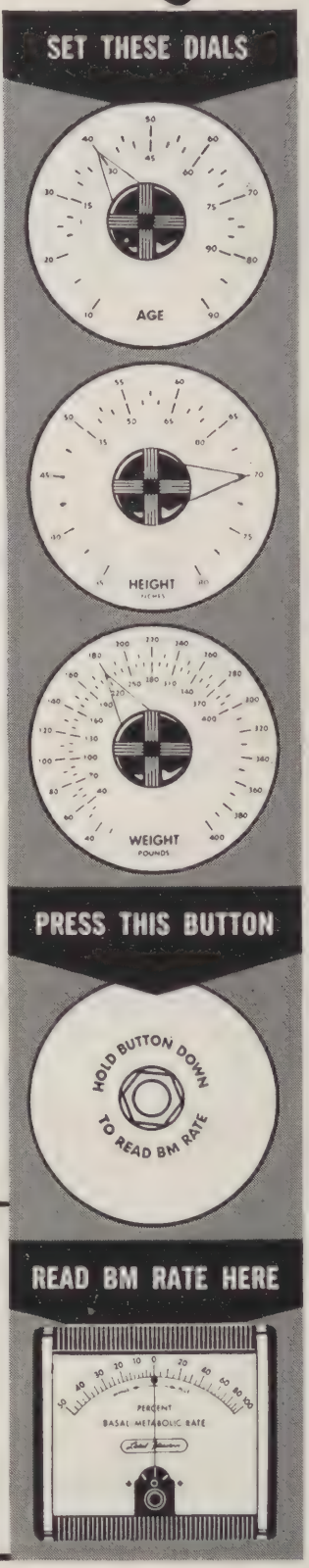
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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians: Developments in Medical and Health Fields

New Federal Aviation Agency proposes to establish post of Civil Air Surgeon to function as director of civil aviation medical program and improvement of safety in air commerce through sound medical knowledge and research in civil aviation. AMA has advocated this move as the first step in obtaining adequate number of qualified medical examiners for airmen and other personnel, in the interest of passenger safety.

* * *

In another aviation medicine development, the Federal agency proposes a change in regulations that would permit airliners to make unscheduled stops in order to provide transportation for persons in need of emergency medical treatment. Present "closed door" policy prohibits unscheduled stops.

* * *

Recent pamphlet issued by AFL-CIO places Forand Bill passage high on list of labor's major objectives in forthcoming session of Congress.

* * *

Veterans Administration plans major new emphasis on studies of mental and physical deterioration associated with aging. VA also had mapped research programs in mental illness, cancer, heart and blood vessel disorders, tuberculosis, and development of new techniques in atomic medicine.

* * *

Unless there is a marked increase in the production of physicians and other health personnel, "not only the total (medical) research effort but the health services of the nation will be severely hampered in the years ahead," Dr. A. C. McGuinness, special assistant to HEW Secretary Flemming, said in an American College of Preventive Medicine address.

* * *

PHS Surgeon General Burney reports Asian influenza outbreaks are expected during this winter but probably with fewer cases than last winter's epidemic. He adds that a new polyvalent vaccine for the disease has been developed.

* * *

Internal Revenue Service has ruled that expenses incurred by a taxpayer in maintaining his mentally retarded son in a home that cares for such cases, such confinement being recommended by a physician, are deductible. The patient had suffered brain damage in childhood and at age 13 his doctor concluded he was so severely disturbed that it was neither safe nor practical for him to remain with his parents.

* * *

Since last winter's campaign aimed at getting more people inoculated with Salk vaccine fell short of its goal, Public Health Service plans to resume the public educational program, with cooperation of AMA, Advertising Council, National Foundation, state and local health departments and private groups.

* * *

Federal funds for Hill-Burton program in 1959 are not expected to reach $187 million record appropriation by Congress in 1958 since that appropriation was made as an anti-recession move and economic conditions have improved, according to Hill-Burton sources.

* * *

American Thrift Assembly has completed plans for action to obtain passage of Keogh bill in 1959, and already is reported contacting members of Congress. Bill would allow self-employed to defer income taxes on a percentage of their earnings if placed in retirement plans.

* * *

New Air Force surgeon general is Major Gen. Oliver Niess, succeeding Major Gen. Dan C. Ogle, who retired December 1, after 30 years of service. General Ogle was instrumental in establishing the Aeromedical Research Center, Brooks Air Force Base, and in constructing 170 new medical facilities throughout the world.

* * *

Washington, D. C. area Blue Shield group, at request of D. C. Medical Society, is studying possibility of setting up a separate medical-surgical care plan for low income groups, including the aged, that would provide regular benefits at a reduced premium. Hospitalization would not be covered.

* * *

GI-trained veterans have helped raise the entire educational level of the United States, a Veterans Administration report states. Census Bureau report indicates that the average head of the household today has 10.4 years of schooling compared with only 9 years in 1950. The Census Bureau attributed the rise largely to the educational benefits of the two GI Bills.

Relieve moderate or severe pain

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Alleviate the general malaise of upper respiratory infections

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Acetophenetidin	gr. 2½
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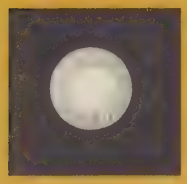


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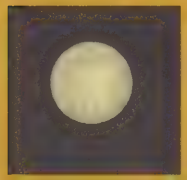
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You and Your Public . . .

Survey Shows Public's Interest in Medical News Is Extensive and Most Likely To Increase

THE physician frequently surprised (and sometimes irritated) by a patient's questions concerning the latest developments in medicine can expect this practice to continue and to expand, if news media heed the soundings of a recent survey.

The survey, conducted on behalf of the National Association of Science Writers, showed that 37 per cent of a nationwide sampling of 1,191 adults read all medical news in the newspapers. Further, 42 per cent said they wanted newspapers to print more medical and scientific news. Even if it meant omitting items concerned with other types of news, 66 per cent said, there should be more space allocated for medicine and science.

Ohio physicians can expect even more of their patients to express interest in such news. The survey indicated that 76 per cent of Midwest residents queried recalled reading specific medical items, while the nationwide average was 69.7 per cent.

Medical News Remembered

It also is interesting to note that an analysis of the survey questionnaires strongly showed that the patient is more than likely to remember medical news once he has read it. This was brought out by four so-called touchstones used by the pollsters.

Those touchstones were polio vaccine, a space satellite, radioactive fallout and fluorides in drinking water.

Some 88 per cent recalled the vaccine, 51 per cent recalled fluoridation, 53 per cent, radioactive fallout, and 23 per cent, satellites.

To substantiate, or perhaps strengthen, these conclusions that such news is read and remembered, let's take a look at the results of a newspaper poll of readers in the Minneapolis area.

The same four touchstone questions were used, with 98 per cent recalling polio vaccine information, 96 per cent recalling space satellite news, 91 per cent, radioactive fallout, and 88 per cent, water fluoridation.

The conclusion drawn by the National Association of Science Writers survey is as follows:

"Appreciation of science in a twentieth century democracy may involve life or death. It is important for Americans to understand what scientists are trying to do and what they are doing.

Huge Reservoir of Interest

"This survey has established that there is a huge reservoir of public interest in science reporting, with many readers, listeners, and viewers willing to give up other news and entertainment features to become better informed about science.

"Media executives might well 'give the public what it wants' and increase their coverage of science developments. With more and more students going through high school and on to college, and with many of them studying science, the market for science coverage in the popular communications channels certainly will expand tremendously in the years ahead.

"Much of the information in the mass media does get through to the public mind and, if the respondents in this survey are typical (and they should be), an impressive amount of this science information is remembered and can be 'played back.'

Improvement Sought

"As some scientists are seldom hesitant to proclaim, there is room for improvement in the popular reporting of scientific developments. Most people in communications concede this. Many are trying to do something about it.

"Reporters and script writers, given more training and more time in assignments, would be able to provide more details, greater background, better interpretation, and, it is hoped, higher accuracy. Such changes might help correct present distortions in the public image of science and scientists (this includes medical science) and promote the idea that they are a part of, not divorced from, contemporary living. Thus the story of science would be more properly recorded and Americans would have information on which to decide more intelligently those public matters involving science, scientists—and possibly their own existence."

What It Means To Medicine

Those are the conclusions of the science writers. Bearing in mind that the physician's public includes his patients and his fellow citizens, the following are some long range developments that the medical profession can expect:

1. News media will gradually enlarge and improve its coverage of medical and other scientific developments.
2. There will be an even greater reader (and patient) interest in medical news.
3. The physician therefore can expect not less

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but more questioning from his patients and his fellow citizens concerning medical developments.

4. News media will call more and more on the local medical profession for information and interpretation of information pertaining to medicine. This also can mean more "depth reporting," and physicians would do well to help the interpretative reporter in order that he avoid "getting out beyond his depth."

What To Write For

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Information for Physicians. This pamphlet outlines the expanded program of The National Foundation for Infantile Paralysis, now known simply as The National Foundation. Write The National Foundation, 301 East 42nd Street, New York 17, New York.

* * *

Preliminary Guide for Measuring Work Absence Due to Illness and Injury. This guide is prepared for industrial health committees and physicians who serve as industrial consultants. Write AMA Council on Medical Service, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

Summary Report on Health and Insurance Plans under Collective Bargaining, Late 1955. For physicians interested in coverage in and provisions of insurance plans under collective bargaining. Write AMA Council on Medical Service, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

For Mother and Dad and **The Time Dede Went To The Hospital.** These two pamphlets which Columbus Children's Hospital distributes to parents and hospitalized children provide a wealth of information for the parents and a fascinating pictorial guide for the child facing hospitalization. Write Children's Hospital, 561 South 17th Street, Columbus 5, Ohio.

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Safe Handling of Bodies Containing Radioactive Isotopes. National Bureau of Standards has published this 20-page guide for surgeons, pathologists and funeral directors. 15 cents. Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.



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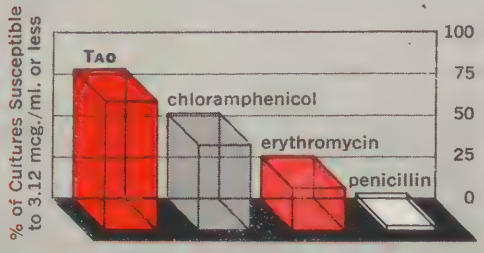
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DO'S AND DON'TS ABOUT HYPNOSIS

Hypnosis appears to be the magic word of the day. More and more patients are demanding its use. More and more doctors—confused over the claims and counter-claims regarding it—are appealing to medical authorities for authentic advice as to its effectiveness.

All seeking advice will find a report of the Council on Mental Health of the American Medical Association on the medical use of hypnosis extremely valuable.

The conclusions of the report, which was approved by the AMA Board of Trustees and House of Delegates, contains these pertinent recommendations and warnings:

"General practitioners, medical specialists, and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It should be stressed that all those who use hypnosis need to be aware of the complex nature of the phenomena involved.

"Teaching related to hypnosis should be under responsible medical or dental direction, and integrated teaching programs should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be discouraged.

"Certain aspects of hypnosis still remain unknown and controversial, as is true in many other areas of medicine and the psychological sciences. Therefore, active participation in high-level research by members of the medical and dental professions is to be encouraged. The use of hypnosis for entertainment purposes is vigorously condemned."

WHY SHOULD FEDERAL HOSPITALS BE TEACHING UNITS?

Commenting recently on certain Medicare Matters, *California Medicine,* official magazine of the California Medical Association, came up with these observations regarding the military hospitals, which observations, in our opinion, make a lot of sense:

"In recent years the federal hospitals operated by the Army, Navy, Air Force and Veterans Administration have enlarged this concept and put themselves in the position of being essential teaching units, purportedly as a means of improving the training of their own medical officers.

"It is easily understandable that military officials are sincerely interested in securing more extensive training for their staff physicians. But such training can be secured through the numerous private hospitals all over the country which today have a shortage of residents in all branches of medicine.

"With surplus residencies in private institutions, why should government add to the total of available residencies by setting up training programs of its own? In so doing, government adds to the vicious cycle of assuming the care of more patients, securing physicians to provide the care, building more beds to handle the patients, using the patients as teaching material and drafting more physicians as clinicians and teachers."

FIVE CHANCES AT LEAST TO DO PR WORK

The average citizen sees his doctor about five times during the year, according to data being compiled in the National Health Survey conducted by the US Public Health Service.

This means that most physicians have five opportunities annually to acquaint each of their patients about some of the opinions and problems of the medical profession. These chances should not be overlooked. They offer the physician an opportunity to be his own public relations agent.

TIME FOR YOU TO BE A CC MEMBER

In recent years tall tales of, by and about Texas and Texans are good for sure-fire laughs in just about any social gathering. An item in a recent A. M. A. Secretary's letter certainly is not in that category. It relates an accomplishment of which the medical profession in the largest city of the Great State of Texas has a right to crow! Here it is:

"Did you know that the Dallas Chamber of Commerce has more physician members than any other chamber in the United States?

"Membership of doctors in the Dallas chamber has grown from 92 in 1953—when only three served on chamber committees—to a total of 340 in 1958, with 34 actively serving on committees."

While we are not in position to substantiate such a claim for an Ohio city, we do know that many Ohio doctors are members of local cham-



nasal and paranasal congestion and control secondary invaders

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pheniramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Trisulfapyrimidines U.S.P.	0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

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bers of commerce. We recall one prominent Ohio physician who made an outstanding record as president of the chamber in his home-town. Recently 14 individuals and businesses joined the Akron Chamber of Commerce. Four were physicians.

Evidence of community interest makes for better public relations for medicine. Doctors are citizens too! It behooves them to support and actively participate in local organizations dedicated to community progress and betterment.

If you are not now a member of your local chamber of commerce, give the secretary a buzz, and ask him about becoming a "professional member."

KNOW YOUR PATIENT WHEN NARCOTICS ARE INVOLVED

See by the newspapers that a woman narcotics addict has been taking physicians for a ride in a number of Ohio counties. She obtained prescriptions from at least 17 different physicians. She sold some of the dope; took part of it herself.

Naturally, the narcotics inspectors are not too pleased at this laxity on the part of so many physicians.

True, it may be difficult for a physician to distinguish between a legitimate need of a patient and imitation. Nevertheless, physicians must know their patients better than that. Certainly they shouldn't run the risks involved in passing out prescriptions for narcotics to every Tom, Dick and Harry.

Better investigate before writing that narcotics prescription!

WHERE DOCTORS MUST GET IN AND PITCH

In our opinion two of the best articles which have been produced todate on the general subject of health services and health problems of school-age children appeared not too long ago in the *AMA Journal*. We recommend them as "must" reading by all physicians. Both offer challenges to physicians.

One article, written by Thomas E. Shaffer, M. D., Columbus, Ohio, chairman of the OSMA Committee on School Health, relates to the health services which school-age children need. It concludes with this pertinent paragraph:

"Continuity of health services is always necessary. The child's physician, who will be called on with increasing frequency for medical examinations, advice, and treatment, will always be the connecting link between medical services, the child's family, and the community organizations, of which the school is the most important. This is a role physicians should welcome, for it improves on the older concept of overly developed health services in the schools. However, this responsibility cannot be met without an understanding of the physical and emotional problems of school-age children."

The second article, written by John L. Reichert, M. D., Chicago, discusses competitive athletics for pre-teen-age children. Dr. Reichert's conclusions, as follows, should be a red flag to both educators and members of the medical profession:

"It is apparent that today's athletic programs suffer from a lack of competent medical advice and supervision. More objective and qualified medical research is needed. More doctors, interested in children and informed on the basic facts of juvenile athletics, are needed to provide medical supervision for school and community athletic programs for preteenagers. If we as physicians are to work toward our stated goal of leading children to secure, responsible, and well-adjusted manhood and womanhood, here is an area where we must get in and pitch."

BETTER CHECK BEFORE YOU SUE

Before you sue for a fee, better be sure the weight of the evidence is on your side and, especially, that the patient you're suing has no complaint regarding the professional care received.

That's the essence of some good advice published in a recent issue of *The Doctor and the Law*, a medico-legal newsletter issued by Callaghan & Co., Chicago, and edited by George E. Hall.

Read the entire article. It's not long but contains some excellent warnings and suggestions for every physician. Quoting:

"One of the leading plaintiff lawyers in the San Francisco Bay area, who spends almost his entire time representing claimants in medical malpractice situations, said that in his experience about 50 per cent of the clients who ask him to file a malpractice case are motivated to do so by a doctor who has sued for what to them is an unreasonable fee. In nine out of ten instances this attorney is convinced that there has been no malpractice and he talks the client out of suing. He feels, however, that doctors are lax in explaining to their patients the difficulties of their particular case and in pointing out some of the serious results which might occur even in the absence of negligence. He believes, also, that it is the doctor, not the lawyer, who should assume the obligation of telling the patient the whole story and convincing him that all was done that could have been done. He therefore offers this very sensible suggestion.

"In every case in which the result was something less than the patient had hoped it would be, the doctor should make a careful and thorough explanation of all the difficulties encountered and of why a perfect result was not obtained. He should then send one bill for the reasonable value of the services rendered. (Not to send any bill might be interpreted as an admission that something was wrong.) If the bill is paid, all right. If it is not, forget the whole thing. To harass a patient who has been dissatisfied with the care given is more likely to result in the filing of a malpractice suit than in the collection of the fee. Most patients, this attorney feels, want to trust and believe their doctor. They are hurt when they get the impression that his primary concern is the collection of his fee. In most cases, a reasonable explanation is all that is necessary."

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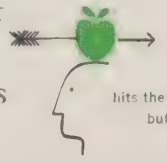
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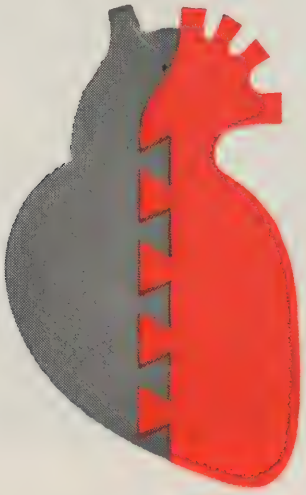
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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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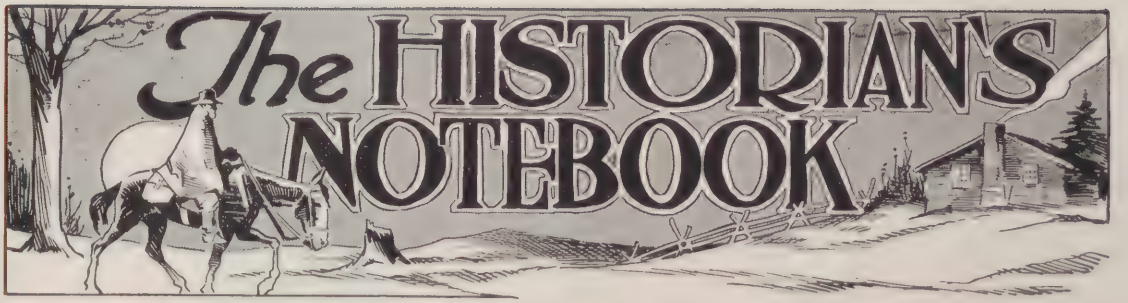
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For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.



Medical Education One Hundred Years Ago — The Introductory Lecture*

GENEVIEVE MILLER, Ph. D.

PART I

EVERY historical moment has unsolved problems, and while we today may feel that we are unduly burdened and may look back with nostalgia to a more serene golden age in the past, our illusions vanish when we confront the actual situation then. Narrowing our field of vision to a tiny fragment of American medical life in the middle of the 19th century here in the Middle West, let us examine the contemporary climate of opinion, the ideals which educators upheld, the evils with which they contended. For this purpose I have consulted a number of "Introductory Lectures" given at the beginning of the school term by professors of medical colleges in this area in the 1840's and 1850's.[1]

Plan of Medical Education

Let us recall briefly the general plan of medical education at that time. After his preliminary education was finished, the teen-age boy "read" medicine for several years in the office of a local practitioner who contracted to supervise his studies and to let him observe his practice. When the student left his preceptor, he could either be examined and licensed to practice by the local medical society, or he could continue his training at a medical college whose diploma conferred upon him the title of Doctor of Medicine and the right to practice without further examination.

The medical college term began the first week in November and continued for 16 weeks, with lectures five to six hours a day. The cost of tuition was about $50.00, or $10.00 a course; board and room could be obtained for $1.50 to $2.00 per week. Two years of attendance, a $20.00 fee, and a short thesis were required for graduation; a third year of study tuition-free was recommended. The same courses were repeated each year. After the school closed at the end of February the students were at liberty to continue their studies privately, to take a job to earn money to pay the next year's tuition, or if they were already in practice to resume their professional duties.

*Presented at the annual meeting of the Ohio Academy of Medical History, Cincinnati, April 26, 1958.

The Author

● **Dr. Miller, Cleveland, is Research Associate in Medical History, The Cleveland Medical Library Association.**

The "Introductory Lecture"

At the beginning of each school year a convocation was held during which an "Introductory Lecture" was given by one of the professors. Although intended principally for student edification, they frequently were open to the public in order to maintain good relations, as the local citizens usually gave financial support to the school, recognizing that it added luster and wealth to their town to have educational institutions in their midst.[2]

After the lecture it was customary for the students to appoint a committee to ask the lecturer for a copy of his address to be used for publication, and nearly all the published lectures contain the official letters between the professor and students wherein the transaction was concluded in the most laudatory fashion. For example, Prof. J.



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*Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. *23*:41 (Jan.) 1958.

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C. Hughes of the College of Physicians and Surgeons of the Iowa University stated in his letter: "Embarrassed by the flattering terms in which you are pleased to speak of the address, and assured that its merits are not equal to the encomiums bestowed, yet desirous to gratify the wishes of the Class, for whose character and talents I entertain the highest esteem and regard, I herewith place the manuscript in your hands, to be disposed of as you may desire."[3]

The subjects discussed were entirely miscellaneous in character, although they generally contained some advice for the students in the conduct of their studies and professional careers afterwards, Usually labelled simply "Introductory Lecture," some had titles like "Homoeopathy," "On the Progress of the Science of Medicine," "Scientific Research," "The Basis Element," "Trials and Rewards of the Medical Profession," or finally the address "Strictures on Some of the Defects and Infirmities of Intellectual and Moral Character, in Students of Medicine" which Daniel Drake delivered in the University of Louisville on November 1, 1847. Eulogies of deceased professors were frequently included, and if a school had just been created, or had moved its location, this might be justified. One assumes that the expense of printing the lectures was borne by the medical college and that they were distributed for the sake of publicity.

Contemporary Problems

What were the contemporary problems which emerge from these lectures? Yes, there were financial difficulties then too, but they revolved around the simple matters of providing an adequate school building and demonstration equipment, for medical science had not yet revolutionized medical education and made the subject enormously complicated as well as expensive. In fact the acknowledged uncertainty of medical knowledge in the 1840's and 1850's was perhaps the greatest problem, for it made the profession especially vulnerable to quacks, faddists, and systematists like the proponents of homoeopathy, hydropathy, or botanic medicine.

Lecture after lecture mentioned the lack of confidence which the public had in orthodox medicine. Dr. John Butterfield, addressing the opening session of Willoughby Medical College in Columbus in 1847, said: "I know it has become much the fashion of late years, and this by men and women high in the literary world, to decry the Medical Profession, as unstable and unsatisfactory, and its practitioners as selfish, bigoted, and unworthy of confidence." Replying to lay critics of the conservative skepticism of physicians when confronted with new theories, Butterfield asserted, "We can prove Homoeopathy by a learned clergyman, and Hydropathy by an eminent novelist; and if you are not convinced of the truth of both, we can add to the former a skillful sea captain, and to the latter a distinguished female writer upon domestic cookery."[4]

"Need we be surprised," stated Dr. H. H. Childs at Willoughby in 1844, "that intelligent men extend to the profession a hesitating and doubtful confidence, when educated physicians differ so widely among themselves, avowing the most opposite views, both in theory and practice. . . . That 'Doctors disagree,' has passed into a proverb."[5]

These were the dark moments before the dawn of modern scientific medicine in European research laboratories. The physical sciences had already developed to the point where they were being applied for the increase of man's comfort and prosperity. The gas light, the telegraph, and photography had recently been introduced,[6] but the study of living nature, and more particularly of human biology was still retarded. We understand today why this was inevitable, since laboratory research in physiology, histology, and microbiology had to be developed, and knowledge of chemistry and physics had to reach a certain level before these sciences could be employed fruitfully in studying biological problems, but a hundred years ago people were impatient for answers. The sick seeking relief from pain were ready to believe any good salesman.

Weakness of Orthodox Medicine

The medical profession still had little insight into the requirements for advances in medical science, and the proposed measures were weak and ineffectual. While urging that unorthodox medical dogmas and systems be rejected, they had nothing to substitute but vague ideas about careful observation and the collection of facts as the true path to discovery. The method of careful clinical observation, which had been developed at Paris and which exerted the chief influence on American medical thought during this period, while useful for differential diagnosis of various diseases, was unable to penetrate the mystery of their cause.

Childs, for example, stated that the true method of advancing and acquiring medical knowledge is to collect facts, to apply the inductive philosophy, and to establish general principles, which was an echo of Elisha Bartlett's *Essay of the Philosophy of Medical Science* published that same year.[7] But he then proceeded to elaborate a theoretical cause of disease — debility, arising either from a deficiency of stimulus or its excessive



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application—which was as much a hypothetical system as any which he castigated.[8]

Those urging the establishment of general principles were constantly having to admit how little they knew.[9] In 1846 Dr. Abner H. Brown of Willoughby told the members of the Rush Medical Society that "it is a question by no means readily answered, whether the views [on materia medica] which generally prevail among medical men are not as incorrect and indistinct as those entertained by the people. Take up any of the ordinary works on Therapeutics, or Materia Medica: how various and contradictory are the opinions given in regard to the value and action of remedial agents. How rapidly have the hundreds of 'specifics', falsely so called, succeeded each other. How little is actually *known* of the *modus operandi* of the most common articles. A new *fact* in Therapeutics, a fact well defined and well established, is a curiosity."[10]

At this time when medicine was deficient in proved scientific knowledge, the general American attitude towards theoretical knowledge weakened it further. Americans were preeminently practical in outlook, and many practitioners thought it was essential only to have information which was directly applicable in medical practice. "In no other country, does this instinct exist in so high a degree as our own," declared Daniel Drake. "So far from being limited to the medical profession, it is an American trait, and it shows itself in all the pursuits of life—in agriculture, the mechanic and fine arts, engineering, commerce, and legislation."[11] This attitude not only resulted in empiricism in practice but discouraged studies in pure science. Practical America was not fertile soil for laboratory research in physiology as pioneered unsuccessfully by the experimentalist Charles Edward Brown-Séquard in the 1850's.[12]

(To be Concluded in January Issue)

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Data Are Being Compiled on Physicians Who Practiced in Holmes County

The Holmes County Historical Society has undertaken the project of publishing a list of the physicians that have practiced medicine in Holmes County from 1825 to 1958. The basic step in the compiling of a list of physicians of the county was made by Dr. A. T. Cole, who read a paper on this topic at a recent meeting of the historical society.

The society would like to have as complete a list as possible and so is appealing to the older residents of the county to send in information about the physicians of the period from 1825 to 1925.

The society would like to know the date and place of birth; the location and period of practices of medicine; where they went if they left the county; dates of deaths and any other outstanding activities of any of these physicians.

Anyone having information is asked to send it to Mrs. Mary Kline, at the Selective Service office, or to Co. Supt. D. C. Egger, Courthouse, Millersburg.—*Holmes County Farmer - Hub.*

Gelatin Capsules First Developed In France 125 Years Ago

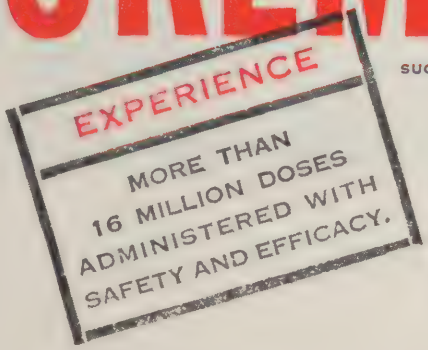
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Vol. 54 December, 1958 No. 12

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Complications of Endotracheal Anesthesia

GEORGE F. PARKER, M. D.

WHILE the advantages of endotracheal anesthesia are well known, the mechanisms of intubation are often difficult. It is for this reason that the disadvantages must be emphasized and re-emphasized to keep the anesthesiologist and surgeon from being lulled into a false sense of security.[1-4] The complications, however rare, which may accompany this technique should never be underestimated.[1] Even with the newer developments in anesthesia technique, equipment and drugs, the act of exposing the larynx and passing the tube can be the most dangerous and critical phase of the entire surgical and anesthetic procedure.

Intubation of the trachea should be available to any patient who may benefit from it; however this form of anesthesia should not be used without justification. Intubation for the convenience of the anesthesiologist rather than for the good of the patient certainly is to be discouraged.

It is true that complications and sequellae occur more commonly during the anesthesiologist's training period and become less frequent as skill develops. Yet, even the most skilled will experience an occassional unintentional complication in the induction phase of the anesthetic, during or after extubation, and in the immediate or late postoperative period. Aside from the major or minor injuries inflicted upon the patient, it is not inconceivable that embarrassing medico-legal entanglements may ensue as a result of intubation mishaps.[2-1]

A modest survey of the literature reveals many isolated case reports of both common and bizarre complications which have occurred during laryngoscopy and passing of the tube. There are a few small series of cases presenting a limited amount of data on the post-traumatic sequelae of endotracheal intubation. In general there are no recent extensive studies which would indicate a statistical account of the prevalence of the various endotracheal complications which are apt to confront the anesthesiologist in his everyday practice.

The difficulties which may be encountered during endotracheal anesthesia may be classified as:

A. Those traumatic episodes which occur immediately.

B. Technical and physiological complications, including undesirable reflex phenomena as well as ventilatory problems.

C. Postoperative complications and late sequelae, some of which are diagnosed and treated by our otolaryngologist conferees, who thereby gain an unfavorable impression toward endotracheal anesthesia in general.

Although there is considerable overlapping in this classification, the complications can be briefly considered in a more or less orderly sequence.

A. Immediate Complications

1. Lacerated or bruised lips and gums.

2. Dental avulsion, loosened, cracked and chipped teeth. (Mostly caused by using the upper

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Read before the Joint Session of the Sections on Anesthesiology and Otorhinolaryngology of the Ohio State Medical Association Annual Meeting, Cincinnati, April 15, 1958.

incisors as a fulcrum for the blade of the laryngoscope.)

3. Contusions or hemorrhage in the pharyngeal mucous membrane or in the region of the ascending mandible, the tonsillar pillars, the tongue base or the epiglottis. (Most frequently, the epiglottis sustains a crushing type of injury from undue upward pressure exerted by the laryngoscope.)

4. Lacerated turbinates or partial adenoidectomy as a result of forced nasal intubation. Occasionally the anesthesiologist not only may lose more blood than the surgeon, but also creates a disturbing hemorrhagic problem which may make any intubation approach far from ideal. Epistaxis can be minimized by adequate lubrication of the tube and by careful technique of passing the endotracheal tube straight back along the floor of the nasopharynx rather than upward with undue force.[16] A comparatively soft tube is mandatory, and shrinking of the nasal mucous membrane is often desirable to assure an atraumatic passage of the tube.

5. Submucosal hemorrhage of the true and false cords.

It is evident that these immediate and largely preventable injuries are inherent in poor direct laryngoscopy, inadequate anesthesia, or both. To avoid these frustrating episodes it is necessary to develop an anesthetic technique sufficient to give adequate relaxation to the jaw and neck structures and to obtund the very sensitive laryngeal and pharyngeal reflexes.

With adequate anesthesia including relaxation the head may be properly positioned, the mouth does not have to be pried open, the tongue may be easily pushed to the left, vision will be unobstructed and the anesthesiologist will have enough time to execute both laryngoscopy and intubation atraumatically. Beecher's statement that "trauma increases directly as the skill of the anesthetist is deficient"[22] certainly draws no argument when applied to intubation technique. There is no substitute for gentleness in manipulating a laryngoscope. Poor anesthesia makes the instrument a dangerous tool whereas good anesthesia facilitates the simple use for which it is intended —the exposure of the vocal cords and the trachea.

Anatomical variations such as recession of the mandible, protruding upper incisors, increased size of the tongue or the short, thick, bullneck type of patient demand faultless anesthesia and laryngoscopy to avoid difficulties. It may be well to consider intubation under local anesthesia in the awake patient as a safer and less traumatic procedure in some of these cases.

B. Technical and Physiological Complications

1. Obstruction to the lumen of the tube. Old worn-out tubes are most apt to kink or collapse. Obstruction also occurs if a patient bites on the tube. This is almost entirely the result of failure to insert an adequate bite block.

2. Faulty position of the tube in the trachea may occlude the bevel against the tracheal wall. Insertion of the tube into the right main-stem bronchus results in inadequate ventilation since the left bronchus and the right eparterial bronchus are occluded.

3. Unrecognized esophageal intubation may lead to asphyxia as well as a dilated stomach.

4. Prolonged manipulation during a difficult intubation may subject the patient to severe anoxia. As the late Rolland Whitacre[17] has pointed out, "More than one anesthetist engaged in such a struggle has been so engrossed with this particular task that he has sighed with relief to see the endotracheal tube in place—only to discover that his patient meanwhile has died because of a simple lack of oxygen."

5. Increased resistance to respiration by tubes which are too small. Hypercapnia, hypotension and undesirable reflexes may occur in addition to the extra physical work imposed on the patient to move gases in this situation.

6. Cuffed tubes offer special technical problems in addition to those already cited.

a. Overinflation occasionally causes the cuff to occlude the lumen of the tube. Failure to recognize this difficulty has resulted in asphyxia fatalities.[18]

b. The cuff may slip down over the distal end of the tube resulting in immediate obstruction.[8]

c. Soft rubber tubes may be compressed by excessive pressure.[18]

d. One fatality from rupture of the cuff has been cited by Lennon and Rovenstine.[5] The injury incurred, the only report of its kind in medical literature, was of the blast type.

7. Laryngospasm. Laryngoscopy and intubation frequently initiate extreme degrees of laryngospasm leading to severe grades of hypoxia sometimes requiring every resource at the anesthesiologist's command to break the spasm.

Generally this group of complications involve hypoxia, hypercarbia and asphyxia, all of which may be serious in the individual patient. Catas-

trophes[12] are more likely to ensue from these causes rather than from the reflexes incurred by the laryngoscope or the tube itself.

Undesirable Reflex Phenomena

Transient circulatory disarrangement such as reflex hypertension, hypotension, tachycardia, bradycardia and certain cardiac arrhythmias are undeniably associated with both laryngoscopic manipulation and the pressure of the tube in the trachea. The relative importance of these circulatory responses in the anesthetized patient are not completely understood or evaluated.[12] Some are no doubt harmful particularly if prolonged or if occurring in the patient who already has a damaged cardiovascular mechanism. Certainly all undesirable reflexes should be avoided as far as possible.

King et al.[6], believe that these unwanted reflexes occur more often during light anesthesia. Denson[23] suggests that the changes in cardiac rhythm during intubation and extubation formerly ascribed to the vagovagal or tracheo-cardiac reflex is really a result of inadequate ventilation either preceding the insertion of the tube or before it is withdrawn. Whether some of these noxious reflexes are enhanced by relative hypoxia, carbon dioxide retention or both, is not clear.[19] There is also considerable doubt whether cardiac standstill can be initiated solely by the laryngoscope or intubation.[19]

Undesirable respiratory reflexes may occur secondary to the mere presence of the tube in the larynx and trachea. Laryngospasm, coughing, bucking, and bronchospasm may be precipitated by the laryngoscope or the tube which may lead to hypoxia and hypercapnia. Pre-intubation spraying of the glottis with a local anesthetic agent in addition to adequate anesthesia and a reasonable degree of skill will prevent most of these disturbing reflexes.

Paradoxically, inadequate ventilation appears to be the major dysfunction in the technical and physiological disturbances caused by endotracheal anesthesia, while the reflex phenomena assume a relatively minor role. Most of the difficulties can be prevented by good anesthesia technique, a reasonable degree of skill and the ever-present quality of alertness that every anesthesiologist should cultivate.

C. Postoperative Complications And Sequelae

1. Minor complications appearing early in the postoperative period include:

a. Rhinitis.

b. Infection in the oropharyngeal wounds caused by unskillful manipulation of the laryngoscope and tube.

c. Pharyngitis.

d. Laryngitis.

e. Tracheitis, usually caused by the tip of a stiff curved rubber endotracheal tube pressing against the anterior wall of the trachea. Unclean tubes are also a definite factor. Overinflated cuffed tubes may produce pressure necrosis on the tracheal wall.[10, 11]

The patient may complain bitterly about his sore mouth or throat, his difficulty in swallowing or his hoarseness. These complaints may even eclipse those caused by the surgical wound. Infection superimposed on mechanical trauma to soft tissue is the primary cause of these complications. Bacterial invasion may arise from organisms already present in the nasal and oropharyngeal cavities or may come from unclean equipment. To quote Robert Smith of Boston, "The anesthetist who lacerates the glottis and then rubs a dirty tube across the wound has committed a serious offense."[7]

2. Various major pulmonary complications have sometimes been attributed to intubation. Presumably, pneumonia has resulted from the passage of the tube through a grossly contaminated area (the nasopharynx in the presence of acute sinusitis, or the oropharynx in the presence of an acute pharyngitis). Routine aspiration of the trachea and bronchi before extubation and the ease with which complete expansion of the lungs can be accomplished during endotracheal anesthesia probably prevent a greater incidence of pulmonary pathology.

3. Edema of the glottis, particularly when occurring in infants and children, can produce a serious type of respiratory obstruction. Jackson[9] has emphasized the anatomical fact that the subglottic tissue of children is prone to edematous reaction because of the relatively greater proportion of loose areolar tissue in its cellular structure. Also, it is obvious that the small lumen of a child's glottis may be occluded by a minimum of swelling. Extreme care should always be exercised to avoid trauma to the larynx of a child during intubation. Failure to recognize infant laryngeal variations can lead to laryngeal trauma and edema and even to death. Postoperative tracheotomy may be lifesaving in these cases.

4. Tracheal and laryngeal edema representing an allergic response to the material incorporated in the tube or the lubricant may occasionally be encountered. The ensuing obstruction may be

severe enough, even in the adult, to necessitate tracheotomy.

5. Subglottic Membrane: In a recent paper[1] this somewhat baffling complication was recognized five times in a series of 2500 endotracheal anesthesias; a rather appreciable percentage when one considers that a tracheotomy was eventually necessary in every case. The condition occurs primarily in women and children usually 24 to 48 hours or so postanesthesia time.[13] The clinical picture is that of acute upper respiratory obstruction being ushered in by a cough, hoarseness, stridor, dyspnea and suprasternal retraction. Without immediate treatment the complications of anoxia ensue.

Mechanism

Since the subglottic area is the narrowest point of the larynx it may be easily injured during the process of intubation, either by the tip of the curved endotracheal tube or the projecting point of the introducer stylet. Prolonged pressure against the subglottic membrane by a deflated and wrinkled cuff can also produce minute superficial abrasions. Leukocytes and desquamated epithelial cells accumulate about the abraded area forming a membranous-like structure. Respiration is impeded in part by this membrane and in part by the reflex adduction of the vocal cords.

Differential Diagnosis

Etsten and Mahler[13] believe that a subglottic membrane is many times erroneously diagnosed as edema of the glottis. This error is most likely to occur if a tracheotomy is hurriedly performed without previous visualization of the larynx. Direct laryngoscopic examination reveals a normal glottic chink, epiglottis and larynx. Bronchoscopy, however, reveals the true nature of the obstruction. Bronchoscopic removal of the fibropurulent membrane is the treatment of choice. Tracheotomy is usually not necessary after complete removal of the membrane.

6. Cartilage and Perichondrial Injuries: Direct injuries involving the epiglottis, thyroid, arytenoid, and cricoid cartilages and their perichondrial covering have been recorded.[3] Dislocation of the cricoarytenoid articulations has occurred. Such mayhem is almost always the result of using brute strength instead of gentleness in the intubation procedure. Improper manipulation of metal introducers and stiff rubber or hard woven silk endotracheal tubes are also dangerous in the hands of the inept operator. Usually the site or the extent of the injury is not diagnosed until later in the postoperative period. Certainly a skilled laryngologist should be consulted if any trauma of this sort is suspected.

Laryngeal Stenosis

The healing process of the cartilages of the larynx is notoriously poor, therefore when these structures have been traumatized, perichondritis, prolonged suppuration, cartilagenous necrosis and scar tissue formation with subsequent deformity may result. Laryngeal stenosis is a late sequelae if prophylactic and remedial measures are not instituted promptly.

7. Contact Ulcer with Granuloma Formation: In contrast to the preceding group of cartilagenous injuries where severe direct trauma plays the major role, contact ulcer is usually the result of injury to the vocal process presumably caused by the presence of the tube in the glottis. This clinical entity long known to laryngoscopists was first described by Chevalier Jackson[9] in 1928 on the basis of 248 personally observed cases over a 40 year period. In none of these original cases was the laryngeal condition a sequela of endotracheal anesthesia or endolaryngeal instrumentation. Clausen[4] described the first case of laryngeal granuloma following intubation in 1932.

This nonspecific ulcer of the larynx is located on the tip of the vocal process of the arytenoid cartilages, and according to Jackson[9] may follow intubation for several reasons:

a. The endotracheal tube acts as a foreign body causing a powerful clamping of the glottic closure. The tube then scrapes over the vocal processes of the arytenoids which project their thinly covered joints against the tubal surface. This mechanism occurs if the tube is introduced before laryngeal reflexes are entirely abolished or if anesthesia diminishes sufficiently to allow the reflexes to reappear.

b. Since the tips of the vocal processes project prominently into the lumen of the glottis, they may be hooked by the slanted open end of the tube.

c. Light anesthesia may not abolish the autonomic movements of the artenoids and they continue to rub the tips of the vocal processes against the surface of the tube.

This latter physiological rubbing mechanism is probably the most frequent cause of indirect trauma resulting in contact ulcer granuloma associated with endotracheal anesthesia. One or both arytenoid cartilages may be involved. Since the reparative power of laryngeal cartilage and perichondrium are extremely poor, flabby granulations tend to form. The healing process is especially frustrated by continued vocal abuse.

To prevent this complication, the anesthesiol-

ogist of course must avoid any gross trauma to the vocal processes. Jackson[9] has emphasized that the use of clean, well lubricated tubes as well as relatively soft and absolutely smooth tubes will minimize the incidence of contact ulcer.

Tubes should be examined before each anticipated intubation and those with the slightest imperfection on the smooth glass-mold surface should be considered unfit for use in the larynx.

Diagnosis

Early diagnosis of injury to the vocal process requires that every patient who has any complaint referable to the larynx in the postoperative period should have at least a mirror laryngoscopy. Some anesthesiologists may be competent in this branch of otolaryngology, but most of us need the help of an experienced laryngologist to appraise whatever pathology may be present. This seems to be the only rational way to detect this unfortunate complication early enough to prevent the serious sequela of a permanently impaired voice, or at its worst, varying degrees of laryngeal obstruction.

With proper treatment contact ulcer and contact ulcer granuloma are curable in practically 100 per cent of the cases. When treatment is not delayed the voice is usually good.

8. Several isolated reports[2] of paralysis and laceration of the vocal cords, perforation of the pyriform sinuses[15] and trachea have appeared in the literature. Permanent voice alterations, secondary mediastinitis and fatalities may be associated with such injuries.

Other than poor intubation and/or anesthesia technique, some occult anatomical deformity or the presence of an unrecognized pathological process, it is difficult to explain some of these rare and bizarre complications. It may safely be stated that most of these accidents are probably preventable.

Summary and Conclusions

Many of the common and less common complications of endotracheal anesthesia have been presented. Various aspects of their etiology and potential causes have been discussed. The opinion is expressed that endotracheal anesthesia should not be used indiscriminantly and that false pride should never deter an anesthesiologist from seeking the aid of a qualified laryngologist to determine the extent of any injuries which may have been inadvertently caused by an anesthesia practice so vitally important to modern surgery as endotracheal intubation.

If the anesthesiologist will produce adequate anesthesia and relaxation for intubation, if he will develop and use the skill and gentleness of the bronchoscopist, and if he will take meticulous care of his endotracheal equipment, both minor and major complications of endotracheal anesthesia will be practically eliminated.

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Primary Diaphragmatic Tumors

Whenever routine chest x-ray reveals an abnormality of diaphragmatic contour, tumor of the diaphragm should be considered. Radiographic examination of the barium-filled stomach should be done if disease of the left leaf of the diaphragm is suspected. Diagnostic pneumoperitoneum then may be employed to confirm the suspicion of tumor. A certain number of diaphragmatic tumors can only be proved by exploratory thoracotomy.—Charles E. Littlehales, M. D., Portland, Ore.: *Northwest Med.*, 57:1309, October, 1958.

Prognosis and Pathogenesis of Acute Glomerulonephritis In Adults—A Review, with a Case Report

DAVID H. GREEGOR, M.D.

COMPLETE recovery from acute diffuse glomerulonephritis is certainly not a medical rarity—in fact, in even the most pessimistic statistical reports it happens in approximately one half of the cases. However, we recently had the privilege of witnessing one such recovery from a very severe acute attack that was definitely unusual and perhaps even remarkable in that the patient underwent a nephrectomy in the first weeks of her illness.

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Case Report

The patient, a 30 year old white female, entered the hospital because of nausea, vomiting, convulsions and anuria. Two months prior to admission she had entered another hospital to determine the cause of recurrent attacks of chills, bloody urine and painful urination. During this first hospital admission there had been no elevation of temperature; blood pressure ranged from 120/80 to 140/100 and intravenous pyelography demonstrated a stone in the pelvis of the right kidney associated with questionable blunting of the calyces. After careful study by both medical and urological services she was considered to have chronic, unilateral pyelonephritis and released to her home for two weeks' trial therapy on a sulfonamide preparation.

Two weeks later she re-entered the same hospital showing no evidence of improvement. A right nephrectomy was performed and the initial pathologic report was acute pyelonephritis with stone. At a later date all specimens were subjected to re-study and final diagnosis was severe acute diffuse glomerulonephritis. Her postoperative course was marked by some vomiting, grossly bloody urine associated with normal menstruation and progressive anemia requiring a number of blood transfusions. Seven to 10 days postoperative her general condition and red blood count were considered satisfactory enough to release her to her home under the care of her family physician.

During her two weeks at home the vomiting increased, urine output decreased, patient became weaker and urine remained grossly bloody. Three days prior to admission she was oliguric and unable to retain even water by mouth. On the day of admission she had two generalized convulsions and was brought to a second hospital.

Physical examination revealed a pale young white female, acutely ill, and semicomatose. Temperature and respiration were normal. Blood pressure 160/100, pulse 112, eye grounds and ears, nose, and throat not remarkable. No palpable thyroid abnormality and no lymphadenopathy. Chest was clear. Heart did not appear enlarged to palpation and the only auscultatory abnormality was a grade II systolic murmur at midprecordium. There was a recent nephrectomy scar in satisfactory state of healing. No palpable abnormalities of the abdomen. There was profuse vaginal bleeding and gynecologic consultation indicated that there were no pelvic abnormalities or pregnancy. Extremities and reflexes showed no significant changes.

Laboratory reported nonprotein nitrogen 141 mg. per 100 ml., hemoglobin 10.9 grams, red blood cell count 2,940,000, white blood cells 19,450 with 86 per cent polymorphonuclear leukocytes, hematocrit 31 per cent, blood sugar 140 mg. per 100 ml., sodium 136 mEq/L. Potassium 4.6 mEq/L, chlorides 87 mEq/L. Coagulation time was seven minutes, bleeding time three minutes, platelets 282,240. Urine cultures grew E. coli, nonhemolytic Streptococcus and hemolytic Staphylococcus aureus coagulase positive.

It was felt at the onset that part of the oliguria could be explained on a dehydration basis resulting from protracted vomiting and decreased fluid intake. The patient was given 5 per cent glucose in water both intravenously and subcutaneously with all members of the attending staff watching carefully for signs of cardiac embarrassment. The first day patient received a total of 1500 cc. Terramycin® was included in the intravenous administration. Four cubic centimeters of 50 per cent magnesium sulfate was given intravenously on two occasions to control the convulsions and mounting blood pressure. Sodium Luminal® was administered intramuscularly.

The second day the patient's condition was much worse. She was in coma and could not always be aroused. Major seizures were frequent. Only hopeful sign was that she began to put out urine and the second day's output was 1000 cc. Urine was grossly bloody, alkaline, specific gravity 1,016, albumin 350 mg. per 100 ml., and microscopic analysis revealed an occasional granular cast in addition to the many red blood cells. Patient was given Bonadoxine,® Terramycin intravenously, magnesium sulfate intravenously, 1 unit of blood and 1500 cc. of saline-free fluids subcutaneously.

The following day her condition remained the same. Eye grounds showed no remarkable changes although there was some blurring of the left disc margin. Vision was blurred. The systolic heart murmur heard at the left sternal border, mid-precordial region, developed a more intense blowing quality and perhaps signified some cardiac dilatation. Nonprotein nitrogen was 152 mg. per 100 ml., CO_2 combining power 26.7 mEq/L and patient still convulsed at intervals. Total fluid administration was calculated on the basis of previous day's output and patient was given 2000 cc. of 5 per cent glucose in water subcutaneously.

Fourth hospital day condition was generally worse. There was some facial edema, potassium 3.7 mEq/L, blood pressure 170/118 and mental confusion. However convulsions decreased in number and renal output remained at a satisfactory level of 1000 to 1500 cc. One thousand cubic centimeters of saline-free fluid was administered.

Fifth hospital day produced dramatic improvement—patient could take fluids by mouth and there was definite

clearing of the sensorium. From that day on improvement was steady and patient was discharged to her home and bed rest on the thirteenth hospital day. At that time blood pressure was 124/80. Last nonprotein nitrogen in the hospital was on the tenth day and reported 102 mg.

Since her discharge patient has been followed carefully and to date shows no signs of any residual renal lesion. Blood urea nitrogen and blood pressure are normal; urine has remained free of albumin and the miscroscopic analysis is clear.

Incidence and Prognosis

Glomerulonephritis is not an uncommon disease but as a cause of death it is listed as less than one half of one per cent. However students and observers differ widely in their estimates of the chances for complete recovery from the acute attack (without entering any segment of the chronic phase). Bright in his original papers in 1827 was very pessimistic but as his experience broadened he became less so. In 1877 Bartels pointed out that many patients were getting along very well with the disease in an arrested state.

Kieth[1], in attempting to formulate some idea as to prognosis in all stages of the disease studied 50 of his own cases which he had closely observed for over 30 years at the Mayo Clinic. He found that, (1) All eight of his acute cases had completely recovered. (2) Four of the chronic cases did the impossible and completely recovered. (3) Some patients took from five to eight years before recovering from the acute attack (latent phase). Many other writers have rather glowing statistics; Sussman,[2] for instance, states that 90 to 95 per cent of the acute cases will completely recover and only two (5 per cent) will develop chronic disease.

Most of the reports[3] however, indicate that less than 50 per cent of the adult cases will completely recover. Murphy[4] followed 205 cases over a period of 2 to 10 years. Only 41 per cent were completely cured at the end of the acute stage. Nine (2 per cent) remained in the latent stage which is characterized by lack of symptoms and findings indicating renal disease except for the presence of significant quantities in the urine of red cells and albumin. There were 12.6 per cent who died in the acute stage and 26.8 per cent entered the chronic stage.

Murphy[4] and others in commenting upon the wide divergency between published recovery statistics explained the more optimistic reports as follows: (1) Although some workers deny it, the recovery rate is definitely better in children and many of the high recovery groups are comprised in the main of pediatric cases. (2) Many observers have failed to recognize the patients in the latent phase. After World War I it was possible to follow large numbers of adult cases and both European and American reports corroborate the 45 per cent (complete) recovery rate.[4]

Accuracy of Statistics

Is the situation actually this bad—is it possible that the acute adult patient has no better than a 50 per cent chance for complete recovery? It is this writer's opinion that the picture is more promising than indicated. Most of the statistics include a large number of patients who first came under medical observation in the chronic stage and who were completely unable to give any history of the acute attack. This has caused a few physicians to consider acute glomerulonephritis and chronic glomerulonephritis as distinct and separate diseases and not as stages of the same illness. This conclusion is not shared by the profession at large but it does indicate that a significant number of people go through an unrecognized acute stage into chronic renal damage.

By the same reasoning it is only fair to conclude that there must be many unrecognized acute cases which clear completely and which are never accounted for in medical statistics. If we couple this deduction with the fact that most case studies where the cases were observed from the initial stage give high recovery rates, we have the right to expect a much better than 50 per cent rate for our acute cases.

Certain questions immediately pose themselves: (1) What factors actually determine complete recovery? (2) Does it depend entirely upon the violence of the antigen—antibody reaction? (3) Or does it depend primarily upon early diagnosis and adequate medical care? (4) Is there any way in which we can predict the eventual outcome for a given case?

Murphy[6] attempted to answer some of these questions in his study of 30 cases selected from all stages of glomerulonephritis. He concluded that, (1) acute respiratory infections played no part in ultimate course; (2) proteinuria was always present but not a finding upon which to base prognosis; (3) cardiac complications were frequent (70 per cent in overall study) but not the chief cause of death and therefore not a principal factor in prognosis; (4) the most practical index to prognosis was the degree and behavior of the diastolic blood pressure. The cases ultimately demonstrating the most renal damage usually showed significant and progressive diatolic hypertension.

Etiology and Pathogenesis

The studies of Rammelkamp[15] and others incriminating members of group A, beta hemolytic streptococcus have been generally accepted. These

studies indicate that only certain strains of the group A are capable of producing glomerulonephritis. To date these strains are type 12 (the most common), type 4, Red Lake[14], and some of type 25.

The medical profession has been very fortunate in its study of glomerulonephritis to have the benefit of many laboratory experiments in which it was possible by immunologic methods to reproduce the disease in dogs, rats and rabbits.[7, 8, 9, 10, 11, 12, 13]

Animal Experimentation

Mellors et al.[11] used fluorescein labeled antisera in rabbits and demonstrated that those animals developing nephritis have a concentration of the antibodies in the glomerulus, particularly in the basement membrane. They concluded as did Seegal[17] from his work in dogs and rats, that the basement membrane must be the source of the antigen which incites the production of the nephrotoxic antibodies. Perhaps it should be pointed out at this time that all investigators are agreed that there is no actual bacterial invasion of the kidney which is responsible for acute glomerulonephritis but that the disease is a direct result of a hypersensitivity reaction[8] taking place among other sites, in the glomerulus.

In further rabbit experimentation the Mellors group[12] injected 15 rabbits with bovine gamma globulin and used their same micro-technical approach. Twelve of the rabbits developed glomerulonephritis and the antibodies were again found in the glomeruli—presumably localized there by the fixation at that site of the injected antigen. In human cases[16] where gamma globulin was used prior to the onset of nephritis, studies of the serum complement suggested that the pathogenesis was, as in the animal studies, an antigen-antibody reaction. Data derived from cases of nephroses and chronic glomerulonephritis has been less convincing along this line indicating there are probably additional pathogenetic mechanisms at work in the development of the chronic state of renal disease.

Other illuminating reports on animal experimentation include that of Bevans et al.[10] that dogs progressing into the chronic stage showed no fresh exudative lesions along the way indicating that the initial insult determined the course because there was no continuous or repeated injury. However the statistics of Murphy and Peters[4] in human cases indicates that prognosis is not affected by the fact that the acute phase is stormy or mild. The importance of pregnancy in the disease has remained controversial—pregnant rats developing nephritis from antiplacental serum would abort whereas dogs neither aborted nor developed the toxemia syndrome.[9]

In animals cortisone inhibited the development of nephritis[8] and perhaps it would do the same in human beings if we only had the advantage of being able to use it before the renal lesions are formed.

Hamilton and Fremes[13] found the dividing line between recovery and progression into the chronic stage to depend upon the state of continuity and integrity of the capillary basement membrane following the initial insult. If this were seriously disrupted the proliferating epithelium of Bowmans[1] capsule laid down collagen with ultimate periglomerular fibrosis obliterating the glomeruli. If the basement membrane remained intact resolution eventually took place.

Attempting to apply Hamilton's conclusions to the case reported in this paper we reviewed the microscopic sections of the removed kidney and noted that although there was widespread glomerular swelling there was little if any destruction of the basement membrane and in general the glomerular architecture was well preserved. Perhaps from this evidence we might have predicted that should the patient be able to survive the violence of the acute attack that complete resolution of the kidney lesions would take place.

Treatment

It is not the intent of this paper to discuss treatment in detail but some comments on relative importance of the various parts of the medical program are in order. The essentials of management during the acute phase are as follows:

(1) Diet

(a) Salt should be restricted to 0.5 gram or less per 24 hours.

(b) Protein content may be normal unless azotemia is marked in which case there would be some restriction. Hypoproteinemia would, of course, call for additional amounts of protein.

(2) Strict bed rest.

(3) Intravenous infusions slowly and only upon definite indication such as dehydration from vomiting, inability to take oral fluids, etc.

(4) Intravenous magnesium sulfate to control convulsions and other effects of hypertensive encephalopathy.

(5) Management of cardiac failure when present.

(6) Treatment of specific infections when present with a special search for the presence of beta hemolytic streptococcal infections.

Among those suggested therapeutic weapons which are of little or no value are cortisone and the

artificial kidney. Usually any patient with acute glomerulonephritis to the extent that he is anuric for several days has so much widespread glomerular obliteration that the artificial kidney can do little but delay the eventual demise.

Kieth[1] in his series felt that salt elimination played the most important part in the whole treatment program. Schnechloth and Page[3] have also pointed out that the major part of their program is built around bed rest and salt restriction. The Murphy and Peters[4] report emphasizes that good results can only be obtained by a close watch over the patient during the latent phase following the acute stage and the use of strict bed rest during this period if any signs of an exacerbation appears.

And finally—a word on prophylaxis: a very widespread epidemic of acute glomerulonephritis took place on the Red Lake Indian reservation[14] in northern Minnesota in the summer and fall of 1953. Cultures grew an untypable strain of group A, beta hemolytic streptococcus. The epidemic was aborted within two weeks by mass prophylaxis with benzathine penicillin; 600,000 units to small children and 1,200,000 units to the older patients.

Summary

It has been pointed out through clinical experience, animal and human experimentation that the following factors influence the prognosis for complete cure in adults suffering from acute diffuse glomerulonephritis.

(1) Proper medical management in which salt restriction is one of the most important features.

(2) Age.

(3) Presence or absence (and degree) of diastolic hypertension.

(4) Complications.

(5) Total effect upon the glomerulus (basement membrane in particular) by the initial hypersensitivity reaction.

(6) Close observation of the patient during the latent phase following the more stormy acute stage.

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Tranquilizing Drugs And Their Misuse

. . . This leads me to discussion of the misuse of tranquilizing drugs in trying to help our patients achieve peace of mind. The casual use of these products for the relief of everyday tensions is not sound medical practice. Granted that many of the drugs are relatively safe, still such use of them does not seem to me to be wise. If we allow such a practice to spread, we can picture our society becoming a very dull one, composed of "tranquilized" people without emotions. There is reason to believe that a certain amount of anxiety, tension, or fear may be necessary stimulants to the finest attainments of man. If we merely tranquilize our patients, we may lull them into a state of pseudo-health and actually we may weaken their adaptive capacities. I have seen many patients who received tranquilizers without relief. They have come for psychiatric help with a hopeless feeling, thinking that if the drugs didn't help, nothing will. It is deplorable to stimulate false hope by promising relief that perhaps can't be delivered.

In order to adapt successfully, one must take thought. One must attempt to know one's self; this is the only way that a person achieves lasting peace of mind. It has been my experience that most patients want this kind of help from their physicians; they don't want to be merely "tranquilized." They are looking for genuine happiness, not just relief of symptoms with medicine. An understanding relationship between the patient and his doctor is still the basis of effective medical practice. This relationship allows the physician to explore the reasons behind a patient's complaints. In such a situation there is no prescribing until a full evaluation of the patient is made; an attempt is made to understand the patient's personality and emotional needs as well as his physical and laboratory status.—Ralph Burbridge, M. D., Erie, Pa.: *Pennsylvania M. J.*, 61: 999, August, 1958.

Medical Research and Medical Practice in Industry

ROBERT A. KEHOE, M. D.

Introduction

WHEREAS in most fields of medical practice, the physician practices, or carries out research, but rarely does both, in industrial medical practice one does both constantly or must be in readiness to do both at all times. It can be said, of course, that every patient in every doctor's practice presents a problem to be investigated, and in this sense all medical practice is research. Such investigations in private practice usually end with the solution, or near solution, or the recognition of failure to achieve a solution, of the problem of a specific patient. In contrast, in the practice of industrial medicine, the patient is often merely the means of opening an avenue of investigation which, having been begun, persists and finds its solution, if any, far beyond the handling of the patient, however satisfactory that may be.

It is recognized that the difference referred to in the two types of practice is one of degree, and that the main divergence of the two lies in the fact that most of the problems of private practice have been with us for a long time and have been illuminated by the work of a host of physicians and investigators. Many problems of industrial medicine, on the other hand, have come upon us fairly recently, and new ones are being created daily, while only a minute proportion of the resources of medicine, up to the present time, has been directed toward research in industrial medicine.

But to return to the initial differentiation, the fact is that research is and must be at the fingertips and in the mind of every industrial physician who understands his job. Indeed, the practice of industrial medicine in our day is research, or so it must become if we are to achieve any significant part of the task that lies before medicine in industry. This fact arises from the nature of the tasks and the methods of research in industrial medicine, and this — the nature of such research — is the main subject of this discussion.

Before entering upon the main discussion, however, it is of some importance to recognize another horn of the industrial doctor's dilemma. It is not enough that he must be both practitioner and investigator, with knowledge of methodology, and skill in its application. He must, in addition, whenever the opportunity presents itself to him as a practitioner of industrial hygiene, be prepared to eliminate the very conditions about to be investigated. Since these conditions have been created by man and not by nature, they can be both understood at once, from the aspect of their origin, and changed almost over night.

From The Kettering Laboratory in the Department of Preventive Medicine and Industrial Health, The University of Cincinnati College of Medicine.

Read before the Section on Industrial Medicine at the Annual Meeting of the Ohio State Medical Association in Cincinnati, April 15, 1958.

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It often happens that preventive measures remove important factors in the production of disease, modify others, obfuscate etiologic and epidemiologic factors, and wipe out, utterly, the clinical material without which a disease entity cannot be observed and described. Thus the substitution of one material for another eliminates a problem, although it may merely postpone its initiation and investigation, and, perhaps, may allow it to arise later under conditions in which the need for research will not be recognized, or in which the capability for research is lacking.

The same result, with respect to the elimination of one aspect of medical research, is achieved when methods of environmental control, devised and implemented jointly by the engineer and the doctor in industry, reduce occupational exposure to materials or sources of energy, and keep it within harmless limits. In the latter situation, however, research will have been employed, usually, to establish standards of safety, and much will have been learned, and one hopes, much of what has been learned will have been made available generally.

The Nature of Research in Industrial Medicine

For many physicians the term research has a formidable and forbidding aspect, as being an

affair of a place apart, an assembly of ideas and techniques far beyond, or at least unfamiliar to, the man of practical mind and hand. If it is not formidable in the sense of being beyond one's understanding and competence, it is forbidding as being impractical, visionary, fundamental in the sense of lacking utility, and pure through being insulated by clinging ivy from all vulgar contact with reality.

With the advent of applied research on the grand modern scale, especially within industry, the concept of research as a sacrament of science, so to speak, has receded, but the fetish of complex instrumentation remains to clothe this field of endeavor with the aura of the unfamiliar in human capacity and performance. This investiture of research with highly specialized qualities is unfortunate, not only in its effects upon its devotees, but upon those who view it from afar, and precisely because it is viewed from afar.

Good research is based primarily upon sound thought—the imaginative and industrious search for evidence, and the examination of evidence critically and systematically. It involves the use of the tools of modern science, which, in essence, represent extensions of the capacity, sensitivity and accuracy of man's special senses. But when, as is often the case, the manipulation of the tools is substituted for the intellectual process, the result is unintelligible, being only contributory to a wider and deeper chaos for being outside the realm of sound intellectual appreciation and critique.

Whether one has in mind, as tools, the automatic machinery for recording observations, the electronic computation of results, or the application of the mathematical formulae and equations of biometry, the problem is the same, in that the instruments cannot penetrate beyond the intellectual vision of their operator. They introduce precision into observation, they provide us with strength and endurance far beyond our capacities, and they increase our speed of performance manyfold, but they do not solve our primary problem. It is still necessary for the investigator to determine what it is that he wishes to know, to postulate where the answer lies, and to plan his strategy in such a manner as to test rigidly the truth or falsity of his postulation.

It is in this atmosphere of sound and often simple logic that we take a look at research in industrial medicine. Considering its urgency, we lay upon it one other requirement, that it give us answers, as quickly as possible—final answers, if possible, but partial answers, if need be—which we can use in our day's work. Industrial medical research is applied research, *ad hoc* research, if you please, contract research, if it must be, but in any case utilitarian research, which will hold at bay, for the time, until we can do more and better, the threats to human life and health—physical and mental—which lurk, often unsuspected, in almost every technological achievement of our time that finds its way into industrial production and service.

FIELDS OF INDUSTRIAL MEDICAL RESEARCH

Industrial Toxicology

The field of research which comes first into the mind of most industrial physicians, especially those associated with industries in which chemicals are manufactured or handled, or in which the processes employed tend to disperse into the air gases, vapors, fumes, mists or dusts, is known as industrial toxicology.

Whether one is concerned with a new substance or one that is well known but has been insufficiently explored or has presented itself in a new guise or a new situation, the problems at issue in relation to industrial health and hygiene are much the same in principle. The questions that arise, in relation to potential or overt industrial hazard, are the following:

(a) How is this material, in its relevant form or forms, absorbed into the human body?

(b) What are the symptomatic responses, if any, of human beings, to its absorption, and what are the pathologic effects, chemical or anatomical, which induce such responses?

(c) What quantities of the material must be absorbed into the human body to induce toxic effects, and what are the relative rates of absorption into the body by way of the various avenues of absorption?

(d) How can one estimate, by the examination of the environmental conditions which set the stage for exposure to, and absorption of, the material, the extent of the danger of human exposure or absorption, and by a mere quantitative extension of this question, what are the specifications for safe environmental conditions?

(e) How can one establish, by the examination of workmen (including the use of clinical laboratory procedures of any relevant type), the extent of the danger of human exposure or absorption, and the proper margin of safety?

(f) What are the criteria for the diagnosis of the intoxication induced by the absorption of the material?

(g) What is the likelihood of recovery from

such intoxication, and what sequelae, if any, are to be anticipated?

(h) What therapy can be given with promise of relief of symptoms and cure of the intoxication?

These are not the questions that are usually asked by the conventional toxicologist, or they are not asked in this manner. I have stated them in the terms of industrial hygiene deliberately in order to separate out from the increasingly conventionalized toxicologic procedures of the laboratory, those that have primary pertinence in the specific instance, with the following two considerations in mind:

First, the cost, in time, money, and the lives of large numbers of experimental animals, of obtaining statistically precise expressions of toxicity, such as the LD_{50}, is often much more than the usefulness of the information can justify. Careful and comprehensive observations, made on a few animals for specific purposes, may be sufficient and are often more meaningful than large numbers of tests made as a routine.

Second, it must always be borne in mind that we are concerned with the response of man to his environment, and not to the reaction of experimental animals to a set of conditions within a laboratory. One cannot translate the toxic reactions of white rats into the forms of human intoxication, without serious reservations; and moreover, the experimental conditions in the laboratory, despite or, perhaps, on account of their rigid control, are artificial and sometimes, indeed, are irrelevant.

Both of the foregoing considerations tend to be ignored unless industrial toxicology is viewed as a means to an end and not as an end in itself. Hence, it follows that the experiments in the laboratory should include appropriate observations on human subjects whenever this is possible, in order to bridge the gap between human behavior and that of laboratory animals. It is equally necessary that the capstone be put on the structure of our toxicologic information, for the purposes of industrial hygiene, by transferring the site of the investigation from the laboratory to the industrial plant. By a judicious examination of the environmental conditions, in concert with general and selected clinical observations on the men who work under such conditions, the basic data of industrial hygiene are gathered. This brings us to the next field of research, not because it is different in its aim, but because, in general, it is carried out by different persons and by somewhat different methods.

Industrial Hygiene

Unfortunately, the term "industrial hygiene," especially in the United States, where it has suffered from fairly general misuse, must now be defined before it can be used. As used herein, and as a decent respect for linguistic precision requires, it comprises the means employed within industry whereby the health of the industrial population is protected and promoted. To be more specific, it includes the measures of environmental appraisal and control, from the aspect of its threats to human health, as well as the measures applied to industrial personnel whereby the impacts of the industrial environment upon human health and disease are explored, interpreted, and manipulated beneficially.

The personnel involved in industrial hygiene in much of American industry are composed of the engineer, as one part of the team (including the industrial hygiene engineer, the health physicist, the safety engineer, the process engineer and the production engineer), whose province it is, collectively, to create, appraise, and control the environment; and the physician, on the other, (with the related and ancillary personnel of medicine and biology, which usually include the nurse, and may include the personnel of general or specialized clinical laboratories, the psychologist, the physiologist, and optometrist, the social service worker, the first-aid assistant, and certain others from time to time, as technical advisors or assistants), whose function it is to learn man's response to specific environmental hazards, and to differentiate between those that are innocuous and those that are harmful.

To speak of the practice of industrial hygiene as research is merely to state the facts of daily experience among the professional people in industrial organizations who are alive to problems of human health that stem from modern technological developments in industry. Two aspects of these problems deserve special comment, both on their own account and as illustrations of the investigative challenge and approach.

The one is concerned with the development of methods for the sampling and measurement of new chemicals or new forms of energy (or for the detection and measurement of such agents in circumstances or conditions under which they have not been encountered previously), and with the adaptation of methods for their control within specified limits. The other consists essentially of a type of clinical investigation which is designed to discover some response on the part of individuals or groups of persons to certain environmental factors which are known or suspected to be harmful when they reach a certain level of intensity.

Prior investigation in the toxicological laboratory, or perhaps prior industrial experience, may

have provided clues which need to be followed with care for their applicability to human beings. The responses sought for may be in the form of symptoms, physical signs, or deviations from normal hematologic, radiologic, excretory or other physiological standards derived from the microscopic, chemical or physical observations and measurements of the clinical laboratory.

It is obvious that in many, if not all, instances, the technical appraisal of environmental factors must be coordinated closely with the clinical appraisal of personnel. Parenthetically, in this period, when the working relationships of the engineer and the physician have not been developed fully and widely, one must view with tolerance, as well as concern, the controversy that arises from time to time within these professional circles over the relative importance of the two approaches.

Time and space will not allow us to discuss in any detail the problems of industrial hygiene that are amenable to the methods of investigation here suggested, or to remark upon the many methods by which they may be attacked. Suffice it to point out, however, the general applicability of such programs of research, and to cite the urgent need for their wider development in industry. First, it is necessary to emphasize the fact, all too obvious to those who have responsibility for the safety of men who work in dangerous or potentially dangerous occupations, that we have very few standards of industrial safety which have been subjected to the test of systematic environmental and clinical appraisal and can now be said to be firmly established.

How many of the "maximum allowable concentrations," so glibly known as the M. A. Cs., and so readily contemplated for inclusion in the statutes of the land, have been substantiated in this manner? And, if I may venture an aside that concerns itself with our professional responsibilities, how many of the investigations of this type that have been carried out partially or completely in American industry, have been published? We as industrial physicians must not be deceived, and moreover we must not be complacent. Let us recognize and admit that there are no acceptable standards of industrial safety with the exception of the few that have been substantiated by adequate clinical evidence under known conditions of human exposure. Let us also recognize that no such standards will exist until we stir ourselves to initiate and carry out the investigations required for the purpose.

Industrial Endemiology

Epidemic diseases may occur in the industrial population and require investigation by the accepted methods of this field. Of much greater and more general concern for present purposes is the approach to the endemic diseases of occupation and to that increasingly significant group, the degenerative and metabolic diseases and the aging processes, which may conceivably be influenced in their incidence and of course by the general or specific hazards and stresses of occupation.

If it is something of a departure from current speech to refer to this field of investigation as "Industrial Endemiology," some justification, other than that of semantics, can be found for such departure at this time, in that the methodology to be employed is incomplete at best and is so meager in its present application as to deserve some special attention from industrial physicians. This is not the time or place for a detailed discussion of this type of research or of the methods which must be developed and perfected if it is to bear sound fruit. Suffice it, for our purposes, to state certain basic conditions which must be met before such a discipline can be brought into actual existence.

The deviations from a normal state of health which are induced by occupational factors may be both acute or chronic in the individual case, just as they may be obvious or obscure in their influence upon the various occupational groups in an industrial population. Thus we have overt occupational injury or disease, which may lend itself readily to diagnosis, and also, perhaps, to effective preventive measures; or we may have insidious injury, or a specific disease process so gradual in its onset, or so similar in its effects to those of nonspecific wear and tear, as to go entirely without recognition or remedy.

In none of these situations will the incidence of the injury or illness be evident, nor will the true significance of the environmental conditions be learned, unless appropriate and properly timed clinical observations are combined with precise and well co-ordinated measurements of the environmental factors. Furthermore, even the best of such observations will fail to serve their ultimate purpose and to justify fully the effort and expense which has gone into their procurement, unless they are recorded in such a manner as to be both explicit and accessible. The full meaning of these words can be appreciated only after some elaboration.

In the practice of occupational medicine the job is not finished when a diagnosis has been made and confirmed in its etiologic relationship to an occupational factor, or when the patient has been handled properly. Indeed it is only well begun, since the case becomes the focal point for an investigation, on the one hand, or the substantiating

evidence of the existence of a hazard which has been in question or under investigation, on the other. At the least, it becomes a vital statistic, which, both as a fact in itself, and as a part of the larger body of facts that may serve well in the elucidation of a disease, should not be buried in the records.

There can be no doubt that the incidence of various diseases of occupation in the United States is far greater than any of our public records would lead us to believe. Any physician or investigator who digs beneath the surface of the available data in any direction can establish this truth for himself. The factors which contribute to this situation are numerous, but three of them are of primary importance.

(1) The large proportion of the industrial plants of the country, especially the small plants, operate without benefit of medical and hygienic supervision, and, of course, without any medical records. The occupational diseases which occur within them must be well understood and obvious, if they are to be recognized as such by physicians in general practice, and not all of those recognized are reported.

(2) Another large segment of these industries have only such medical advice and supervision as may be provided by physicians whose main interests and abilities are devoted to other types of medical practice, and they obtain only such benefit of industrial hygiene engineering as can be offered by technical and production personnel whose chief competence lies in other technical fields. Under these conditions also, occupational disease of mild or chronic character occurs unnoticed as such.

(3) Even within the relatively small group of industries in which the employees are well supervised medically and hygienically, the records of specific employment, and those concerned with initial and periodic medical examinations, are usually so poorly adapted to the requirements of statistical analysis, that the information contained in them, accurate and potentially useful as it may be, is almost utterly inaccessible because of the time and expense required to assemble it. From the aspect of the vital statistics of health and disease, the result is essentially the same as if the recorded observations had never been made.

The importance of good medical and hygienic records, in the care and supervision of industrial employees, has been stressed frequently, and the emphasis on this point has resulted in a considerable improvement in industrial medical records in recent years. There is much less recognition, however, of the importance of making use of modern techniques of recording which facilitate prompt and productive statistical surveys of the accumulated data.

The careful, skillful periodic examination of industrial employees provides the raw data without which no study of occupational disease or stress can be carried out, and nothing that is done thereafter with such data can render them one bit more precise or trustworthy. They are the grist of endemiological investigations in industry, and without such grist of high quality the procedure is doomed to sterility. Under ordinary circumstances, however, these data must be handled with imagination and competence and with an understanding of their significance, if they are to serve the purpose of revealing the hygienic status of a segment of the industrial population.

To this extent, the industrial physician, with his observations on employees made through years, perhaps a lifetime, of employment, is the primary investigator in the field of industrial endemiology. To be sure, a survey of an industrial population, made on one occasion by a competent team of medical and engineering investigators, can learn much about the immediate status of the employees and about the industrial hazards of an industry or series of industries. Nevertheless, the true picture of the situation can be revealed only by systematic and comprehensive observations made over a long period of time. There is no adequate substitute for in-plant medical and hygienic supervision, for the purposes either of securing the facts or doing something about them.

The application of industrial endemiology to the field of public health, as the latter is influenced by the spread of industrial hazards into the community generally, may require some adaptations and modifications, which at this time must be left for future consideration. It is neither irrelevant nor premature, however, to call attention to the fact that the effects, upon human health, of the pollution of water and air, soil and food, with industrial products and wastes, can hardly be known in their significance, until not only suitable techniques but also appropriate means for the field application of such techniques have been developed for the investigation of large numbers of persons in the general population. It seems reasonable to suppose that such means of investigation can best be developed and tested for their sensitivity and practicability within industry, after which they can be applied, with the necessary modifications, to the broader problem.

A Resumé of the Function and Purpose Of Columbus Receiving Hospital For Children

NORMAN S. BRANDES, M.D.

COLUMBUS Receiving Hospital for Children, located at 800 North Nelson Road, Columbus, Ohio, is a long term, intensive, inpatient psychiatric treatment center for emotionally disturbed children, which has a functional relationship with other agencies in the community that care for children or offer help to emotionally disturbed children. It also has the same relationship with Ohio state-wide facilities.

Unlike institutions for delinquent children, orphaned and mistreated children, and schools for disabled children, etc., a children's psychiatric hospital has a certain definition. It is a medical institution which has the function of the diagnosis and treatment *in residence* of children with psychiatric disorders. It provides around the clock treatment for children whose needs make such a regime the treatment of choice, in distinction to outpatient or other types of treatment. Decisions about intake and discharge, based upon diagnostic and therapeutic findings, are made by the staff of the hospital consisting of the psychiatrists in charge and the social case workers, psychologists, teachers, and child care workers.

Selection of Children

Not all children who need psychiatric help require the specialized services of an inpatient psychiatric treatment center for children. They can be given psychiatric aid while they live in their own homes, while they are in foster homes or in a nonmedical institutional setting. Columbus Receiving Hospital for Children admits only those children who cannot be treated in such places and who must be removed from the family constellation and given intensive treatment while the members of the family are treated intensively as outpatients!

The geographic source of referrals of the children of Columbus Receiving Hospital for Children is 70 per cent Franklin County and 30 per cent outside of Franklin County. Child Guidance clinics, private physicians, pediatricians, church-sponsored guidance centers, as well as schools and boards of education in various communities can make referrals to the Columbus Receiving Hospital for Children. A social case history, or suitable substitute, as well as some basic psychological testing is necessary at the time of referral. This material helps the staff to screen out in advance those cases which would be undesirable for treatment.

Once the staff decides to perform the initial psychiatric intake examination on the family, then all parental figures concerned as well as the child are given intensive examination including psychological testing. This information is presented to the entire staff at the time of the intake staffing on a weekly basis. The intake staffing takes anywhere from one hour to one and one-half hours to complete. After a discussion of the entire history, the staff, by vote, renders a decision as to whether or not they want to take the child. If the child is not accepted, then a recommended disposition is made to the source of referral.

Reasons for Selectiveness

The psychiatric intake process is highly selective for many reasons. First of all, a maximal investment of money, time and energy is made in the treatment of each child. Admitting more children than the number for which Columbus Receiving Hospital for Children can provide adequate care and treatment would jeopardize this focus of investment. Also, there is the risk that possible jeopardization of treatment for the group of children already in residential care may take place by the admission of children who may be disruptive to the therapeutic group or who have types of psychiatric disorders that the staff and hospital are not equipped to treat. Some mentally ill children are untreatable within the limitations of our present knowledge and treatment techniques. Therefore, the intake policy is so geared that only children with psychiatric disorders that can hopefully respond to treatment are admitted to this hospital.

Psychiatric hospitals which treat children are

The Author

● **Dr. Brandes, Columbus, is Assistant Superintendent and Acting Superintendent of the Columbus Receiving Hospital for Children.**

Presented in part before the Fourth Annual Mental Health Institute, Lima, Ohio, May 9, 1958.

responsible for the acts of the children under their care and for what they do both on the hospital grounds and elsewhere in the community. It is therefore necessary to take only those children which would not be threatened by the "openness" of this particular institution. There are no closed facilities available at Columbus Receiving Hospital for Children. There are gasoline stations, heavy traffic, a creek and other hazards and sources of potential difficulty for children which are accessible on the property or near the property. Severely disturbed psychiatric children who cannot distinguish between right and wrong and who are unable to accept limits cannot be admitted to this "open hospital" because of these dangers.

Some day, if we are ever granted the facility of a closed unit, then we can take such children. At this time, it would be extremely unfair to the child and place the hospital in a dangerous position of accepting responsibility for which it is not geared to handle. Children who have the primary problem of brain damage, epilepsy or mental retardation and who *are not* emotionally disturbed are not eligible for admission to Columbus Receiving Hospital for Children. However, many of our children do have minimal brain damage, epilepsy and impaired intellectual endowment *but* their basic problems are emotional in nature.

There is a definite age restrictiveness with regard to the intake. Only children between the ages of 6 and 11½ can be admitted. In other words, Columbus Receiving Hospital for Children deals only with the problems of the school child (not the preschool or adolescent group).

The Definition of Staff And Its Functions

The following personnel are necessary to satisfactorily manage an inpatient psychiatric facility for children, such as Columbus Receiving Hospital for Children: (1) Psychiatrists, (2) psychiatric social case workers, (3) psychologists, (4) child care workers, (5) teachers, (6) a consulting pediatrician, (7) cooks, (8) maintenance and cleaning people, (9) a business staff and secretarial staff. In addition, it is necessary that an active Board of Directors, properly constituted, work with the hospital in order to give the hospital roots in the community and to support and interpret the hospital's therapeutic program to the public. It also represents the community's interest in the work of the hospital. These are but some of the necessary functions of a Board of Directors for a children's inpatient psychiatric facility, such as the Board of the Children's Mental Health Center, Incorporated.

It is the obligation of the administrative and treatment staff of the hospital to communicate in an understandable way with its Board of Directors so that members of the board can know just what the hospital program is all about. The language and application of psychiatry can be quite complex and unless the staff of a children's inpatient facility for psychiatric treatment communicates its feelings, treatment policies and other important roles to the board, then a great gap of misunderstanding exists which certainly cannot be as constructive as the more positive approach of good communication.

The recommended ratio of child care workers to each child should be one worker to three children. This ratio was agreed upon as necessary by the conference on inpatient psychiatric treatment for children held at Washington, D. C., October 17-21, 1956, under the auspices of the American Psychiatric Association and the American Academy of Child Psychiatry.[1]

While the children are in residence and in treatment, the child care workers serve as their parental substitutes. They provide shoulders for the children to cry on, set limits on acting out children, and focus upon children who find it necessary to withdraw into fantasy and unreality. The workers more or less integrate the children's activities and supervise the children's behavior from the time they get up in the mornings until the time they go to bed at night and through the night while the children sleep. The child care workers of Columbus Receiving Hospital for Children are considered to be "milieu therapists."

Milieu Therapy

A simple definition of milieu therapy may be said to be: "The concentration of therapeutic techniques on the everyday behavior, interpersonal relationships and problem situations of the patient by trained personnel, in group and one-to-one realistic situations." Our child care workers are college graduates, within the age range of 20 to 30. They must have stable personalities, be mature individuals, and demonstrate an inherent capacity for withstanding the emotional impact of dealing with our emotionally disturbed children. Therapeutic interaction with the child in residence takes place in the play areas, at the dining tables, and in the environment of the hallways and bedrooms.[2]

The clinical psychology department is responsible for the psychological intake process on the child. Such testing may reveal evidence of brain damage or severe psychopathology. The clinical psychologists are assigned case loads in therapy under the supervision of the assistant superintendent. This section of the hospital participates in the supervision of the school teachers and helps to coordinate planned projects involving the chil-

dren with the therapeutic recreational activities of the child care workers.

It is a fundamental principle of our society that public education must be available for all children. It follows, therefore, that each child be afforded an opportunity to engage in an educational program that is commensurate with his ability, so that he may make maximum use of his intelligence and capabilities, and thus, be better equipped to resolve his problems of living. The educational needs of our emotionally disturbed children are met within this institution. A staff of three well qualified and trained teachers, under the supervision of a psychologist and the psychiatrist in charge, formulates a school program with special emphasis on academics and remedial reading. This educational program is patterned very much after the public school system.

Children are divided into small groups of four and five to a class. All groups rotate through academics, crafts, recreational periods with the child care workers and other activities necessary in their cultural and social as well as educational development. The educational program of Columbus Receiving Hospital for Children is fully approved by the Columbus Board of Education and the State Board of Education. Although many of our children have a normal, or even above average endowment, nevertheless, a sizable portion do require special learning techniques and remedial sessions.

Psychiatric Social Case Work

The role of the psychiatric social case work department in a children's psychiatric hospital brings the social case workers into much closer contact with treatment and administrative functions than in other psychiatric institutions. Under the close supervision of the psychiatrist, the social case work department handles all referrals from initial telephone calls or letters to the staff presentation of its history. Also, under psychiatric supervision, the members of this department are assigned parents and children in individual therapy.

The social workers are directly responsible for the activities of the child care personnel and the dietary department. The last function of the psychiatric social case work department is necessary because food must be prepared and served to the children with as many wholesome attitudes as possible. The cooks, being human beings, could not possess such beneficial attitudes in the kitchen unless they were helped with their own interpersonal problems of living. Therefore, one of our social case workers is assigned to be in direct charge of the dietary service. This department has a definite community responsibility inasmuch as it relates to other community agencies, organizations and professional individuals in the field of mental health in order to share common knowledge, facilitate treatment and provide for mutual understanding.

In addition to the clinical psychologists mentioned previously, the institution employs a research psychologist who directs, with the assistance of the psychiatrist, a far reaching group of research projects. The basic research project to which this department will be devoted is "Project No. 49." This rather complex research project which has been going on for several years has the purpose of determining the effectiveness and applicability of various forms of treatment being used today in child psychiatry. It is hoped that information obtained from the results of this project as well as other associated projects will definitely help national agencies and local agencies in terms of providing a better comprehension of what to do with emotionally disturbed children. It will also serve the secondary function of providing very important material for the use of public and private schools.

Definition of Treatment

The psychiatric treatment of emotionally disturbed children may be defined as follows: "The application of milieu, recreational, individual and small group techniques, as well as educational and remedial techniques, to the problems of living that each child admitted to the institution experiences, so that the child can eventually develop more healthy and comfortable methods of handling these problems of living for himself." Therefore, in addition to the educational and milieu programs described, there are also individual therapy and child guidance sessions offered the parents by means of weekly outpatient appointments and individual psychotherapy offered to some of the children on a three hour a week basis.

These therapy loads are assigned to the staff members and are also assigned to trainees, such as social case work students, psychological interns and psychiatric residents in training, under the close supervision of the psychiatrist. One of the obligations of a psychiatric hospital for children located so close to so many colleges, social agencies and hospitals is to provide training for people who will hopefully stay in our state community and engage in mental health efforts. It is well known that there is a tremendous shortage of qualified, well-trained personnel in not only the field of child psychiatry but in the field of mental health.

When a child becomes upset or experiences an impulse to act out, such as breaking a window, taking a brick or large stone and smashing plaster

out of a wall, or hitting a staff member or another child, then external limits must be imposed. Columbus Receiving Hospital for Children does not use straight jacket techniques, tubbings, punitive controls or electroshock therapy as methods of controlling antisocial or acting out behavior. Instead, we have throughout the building "freedom rooms" or quiet rooms. If the child infringes or acts out against another member or members of his peer or adult group situation, then he is put into one of these freedom rooms by the worker or adult that has been infringed upon for a period of 10 minutes to perhaps 30 minutes.

"Freedom Rooming"

During this time the child can scream, curse, kick his feet or simply sit in solitude until he is less upset and feels once more that he can join his social group. Thus, the freedom room technique of isolation for upsetment in children has two meanings: (1) To act as an external control for the child so that he can build up his own internal controls for the future and (2) to provide an atmosphere of privacy, seclusion and isolation so that an upset child can experience his right to be upset, sort of "get it out of his system" and then return to his group.

The children accept the isolation technique amazingly well. Although sometimes they kick and fuss (thus requiring two or three workers to hold a fairly husky boy and bring him to the freedom room) nevertheless, they learn to respect the meaning of the freedom room and isolation. They learn that it is not a place to be feared and they expect "freedom rooming" if they infringe. In this way, a base line is built up for each child on which he can build his own self-controls so that he will become a more acceptable member of his community not only in the hospital setting but after he is discharged from the hospital. Occasionally, the children *will ask* workers or other personnel to place them in the freedom room if they are upset, for a short period of time.

Staffing is Intensive

Each case in therapy and in residence in this institution is staffed on a rotating basis. These confidential case presentations are held three times a week. Each therapist involved in the case reports on the progress and asks the staff for its opinion as to prognosis and disposition. The teachers and child care workers who are closely involved with the children in their milieu activities report on the progress and behavior of the children at daily staff conferences as well as during the therapy presentations. Thus, a very close check is kept on the treatment investment made in each family and in each child. Only when the staff feels that further investment is useless or that investment has paid off and maximal hospital benefit has been achieved is the child discharged from Columbus Receiving Hospital for Children.

In the past, several families have withdrawn their children from treatment, as will happen in any open, voluntary type institution. Occasionally, the staff makes an incorrect prognosis at the time of admission and takes a "sicker" child than it is geared to handle. When this happens, the child is usually referred to another agency. For example, not too long ago we admitted an extremely psychotic child and it was necessary to refer this child to the local state hospital because he would have to wait too long to be admitted to the closed unit at Longview in Cincinnati.

Summary

A description of the referral technique at Columbus Receiving Hospital for Children together with comments and descriptions about the staff, treatment, and the functioning of the hospital, has been outlined in the foregoing. Sometimes, very little therapeutic reward is obtained except over a very long period of time. It is felt that this particular hospital has a group of devoted staff members who work at their jobs with one common goal in mind: *The treatment of the emotionally disturbed child which has been admitted to its care and responsibility.*

Every staff member at this institution from the psychiatrist in charge to the cleaning personnel has an important role to fulfill: *To prevent severe adolescent and adult psychiatric difficulties and to produce a future healthy member of our familial and sociocultural community.*

References

1. Gardner, G. E., and Greenwood, E. D., et. al.: Psychiatric Inpatient Treatment of Children. 1601 Edison Highway, Baltimore 13, Md., American Psychiatric Association, 1957.
2. Brandes, N. S.: Some Possible Meanings of the Hallway Interview. J. Nerv. & Ment. Dis., October-December, 1957.

Problem in Management Of Rheumatic Fever

The extreme problem in the management of rheumatic fever is not the treatment of the symptoms of pain and fever nor the signs of brain, joint or skin involvement, but is the management of acute carditis and/or its complications. All other signs and symptoms of rheumatic fever are reversible and self-limited with or without treatment. The carditis of the initial attack may be self-limited or respond to therapy but with an increasing number of subsequent attacks this becomes wishful thinking and congestive failure invariably results.—Jos. R. Christian, M. D., Chicago: *South Dakota J. Med. & Pharm.,* 11:360, Sept., 1958.



TOPIC THIS MONTH:

Maternal Deaths* Involving Toxemia

Case No. 208

This was a 23 year old, white, gravida I, Para O, eight months pregnant who died seven hours after cesarean delivery. Her family history was remarkable in that her mother had had eclampsia with two of her pregnancies and her aunt had died of eclampsia! Her past history was not significant. The prenatal care was competent and adequate. A presumptive diagnosis of twins was made and confirmed by x-ray on August 14 at 30 weeks gestation. Her last prenatal visit was September 17 (35 weeks) at which time she had normal urinary findings, blood pressure 120/70, weight 138 pounds, no edema.

She was next seen at 10:00 a. m. September 19 in the hospital emergency room in a generalized convulsive state. She was given 7.5 gr. Sodium Amytal®, 2.0 gr. sodium phenobarbital, 10 cc. 50 per cent magnesium sulfate intramuscularly and 0.5 cc. Verenteral® intravenously; 7.5 gr. Sodium Amytal was repeated in 20 minutes; 5 cc. of Verenteral in 500 cc. 5 per cent glucose was given by slow drip. The initial blood pressure was 160/110. It gradually declined under therapy.

At 12:00 noon September 19, she was given 100 mg. Demerol®, and thereafter she was given 50 mg. intravenously at intervals. An indwelling catheter was inserted. By 4:30 p. m. she had put out 15 cc. of urine which showed 2 plus albumin. By 8:00 p. m. she had put out 30 cc. which showed 4 plus albumin. Surgical emptying of the uterus was vetoed at this time because of anuria. Blood chemistry the afternoon of admission showed blood urea nitrogen 15.0 mg., uric acid 4.8 Gm., CO_2 combining power 12.4 vol. % She received 1750 cc. of fluid from 7:30 a. m. to 3:00 p. m. and another 3300 cc. from 3:00 to 11:00 p. m.—a total of 5050 cc. in the first 12 hours of hospital admission. Total output during that time was 470 cc.

The next morning (September 20), the patient seemed to have improved. Blood chemistry then showed blood urea nitrogen 18.5 mg., uric acid 6.0 Gm., serum sodium 120.0 mEq., serum potassium 3.4 mEq., CO_2 combining power 16.0 vol. %, the serum chlorides 107.7 mEq.; the fetal heart was audible; the urinary output from 7:30 a. m. to 3:30 p. m. was 350 cc. After urological consultation cesarean section was approved.

Sometime between 5 and 7 p. m. the patient vomited and supposedly aspirated vomitus for she went into respiratory failure and cyanosis. Pulse rate 120, respiration rate 28. A bronchoscope was passed and a quantity of frothy white fluid was obtained. There was some question whether this was pulmonary edema fluid or vomitus. The fetal heart sounds disappeared during this episode. On September 20 (at 35 weeks gestation) a classical cesarean section under local anesthetic was done (shortly after) with the delivery of stillborn twins. Following surgery the patient experienced a short period of stability but respiratory difficulties continued. All heroic measures for the treatment of pulmonary edema were done but to no avail. Death occurred on September 21, seven hours postoperative. Autopsy permission was not granted.

Cause of death: Fulminating eclampsia; acute pulmonary edema.

Comment

The majority of the Committee felt that this was a nonpreventable death. One member questioned the element of surgical interference after the death of the fetuses. Another member expressed concern over the amount of barbiturates administered. On the whole the Committee felt that the case was carefully managed and was complimentary in the appraisal.

As a minority member, this reviewer felt that the patient was over-treated and over-studied. The initial treatment is a matter of individual preference and experience. In cases of fulminating toxemia no more than five to six hours should be spent in evaluating the patient, stabilizing the patient, and making sure she is well oxygenated. Anuria in toxemic state should not rule out emptying the uterus by cesarean section. The uterus should be emptied in the easiest and quickest way possible. The writer felt that procrastination was a glaring fault here. The next biggest complaint was the 5000 cc. of fluid given in the first 12 hours of hospital admission. This brings to mind five similar cases reported by Mengert several years ago in which he attributed the cause of death

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

to excessive use of fluids in the treatment of toxemia.

Case No. 126

This patient was an obese 38 year old, colored, gravida XII, Para VIII, abortus III, at term who died one and one-half hours postpartum. Her past history showed bronchial asthma. No prenatal care. She was admitted to the hospital at term, in active labor. On admission hemoglobin was 7.0 Gm., blood pressure 210/110, massive leg and ankle edema, 3 plus albuminuria, moist rales in both lung bases and a frank breech was presenting.

Chronology of labor and delivery: 3:25 p. m. admitted, membranes intact, labor active; 7:00 p. m., cervix completely dilated, good labor pains; 9:05 p. m., open drop ether started, scopolamine 0.4 mg. given beforehand; 9:15 p. m., patient developed laryngeal spasm, blood pressure dropped to shock level. She was intubated and bag respiration started. The blood pressure came up; 9:52 p. m., breech extraction started; 9:55 p. m., cardiac arrest, thoracotomy performed with cardiac massage; 10:05 p. m., breech extraction completed with delivery of stillborn 9 pound 12 ounce male; 11:30 p. m. patient expired. No convulsions were recorded. Autopsy permission granted.

Cause of death (certificate): Puerperal eclampsia; contused heart; hypertensive cardiovascular disease.

Pathological Diagnosis: Cardiac Hypertrophy and Dilatation; Contused Heart; Acute Myocarditis; Focal Necrosis of Liver; Proximal Tubular Necrosis of Kidney; Pulmonary Atelectasis and Hyperemia.

Comment

The Committee voted this a preventable death of patient's responsibility; she had not sought prenatal care. There was some question as to why the state of toxemia was not treated. Even though blood was available there was no attempt to treat the state of anemia. The patient's oxygen needs from the standpoint of toxemia, obesity, congested lungs, color of skin, open drop ether, anemia and general pregnant state were poorly evaluated. The Committee surmised that it might have been easier and safer to have left the patient alone and to allow her to deliver the breech spontaneously with 100 per cent oxygen by mask, and use every little anesthesia. The Committee's final vote succeeded by a narrow margin over personnel responsibility.

Case No. 186

This patient was a 24 year old white, gravida I, Para O, at term, who died two days postpartum. Her past history was not remarkable. Her prenatal care was adequate. The prenatal course contained several interesting facets. She had severe nausea and vomiting starting two weeks after conception and lasting for the first four months. This necessitated two separate hospital admissions for rehydration and extra care. The second and third trimester was characterized by a voracious appetite. She had a 40 pound weight gain, none of which could be attributed to fluid retention. She was negligent about her prenatal visits the last two weeks before admission, when questioned by phone she said she was "too busy."

On receiving a frantic phone call from the husband that his wife was convulsing, the attendant made a home call and found the patient in a coma. Her blood pressure was 240/120. She was hospitalized. Labor ensued spontaneously, and after nine hours of hard labor a stillborn 7 pound fetus was delivered by low forceps and mediolateral episiotomy; no anesthesia. Very little blood was lost after delivery. There was no record of therapy except a notation that convulsions were controlled with difficulty.

Shortly after delivery the patient went into shock. Routine shock therapy was instituted. Blood was given. Shortly afterwards renal shutdown was noted and she was transferred to another hospital for the use of an artificial kidney. Death occurred one day, eight hours, and 20 minutes after delivery. An autopsy was permitted.

Cause of death (certificate): Acute hyperpotassemia; eclampsia of pregnancy; acute renal shutdown.

Pathological Diagnosis: Extensive focal necrosis of liver; retrogressive changes in the convoluted tubules of kidney; bilateral marked pulmonary edema; petechial hemorrhages of myocardium and liver; cerebral congestion and edema; generalized acute passive congestion.

Comment

The Committee voted this a preventable death, the patient's responsibility. The members emphasized the importance of frequent prenatal visits during the last four weeks of gestation. There was some question raised as to the advisability of making a home call on a patient at term in convulsions. Some valuable time for definitive treatment may have been lost. There was no record of blood chemistry finding to support the first diagnosis listed in the cause of death.

Comment of Consultant

The following comment of a consultant who is a specialist in obstetrics and gynecology, was given at the request of the Committee.

Case No. 126 provides a somewhat unusual opportunity to combine hindsight and foresight. Here is a patient admitted to the hospital with hypertension, albuminuria, marked anemia, indications of cardiac decompensation and a full term breech and in labor. Her labor was reasonably short and nearly devoid of medication. During delivery she developed laryngospasm and blood pressure collapse to shock level. The autopsy findings are with the case report.

The Committee voted this death preventable although it's not easy to see just what in the way of treatment would have offset her overwhelming combination of pathology. Certainly if there is any blame it is on the patient. On the other hand, suppose she had been intensively treated for hypertension then the question might have arisen if "overtreatment" had not caused her blood pressure collapse. Admittedly she was in bad shape for hemoglobin but she was not a good subject for adding much of anything to the load on her heart.

Open drop ether might be open to question but the attending physician can be glad he hadn't given a spinal since her blood pressure collapsed, or Pentothal® since she had laryngospasm or magnesium sulfate since she developed cardiac arrest. Had he used any of these drugs they would certainly have been held to blame for these conditions which, it so happens, the patient developed with-

out them. It is easy to say since she died she might better have been left to deliver spontaneously but had she been allowed to do so she would surely have died anyway and then the question would have arisen as to why some attempt had not been made to expedite the delivery. Had she survived the delivery she surely would not have lasted long and her life would have been a burden, as it probably was before.

Case No. 186 illustrates a popular fallacy among patients. A great many of them seem to think that prenatal checkups stop at term no matter how long labor may be delayed. I would certainly question the statement that she gained 40 pounds *none of which could be attributed to fluid retention.* I recently saw such a patient who lost 14 pounds in two days of hospitalization on the same diet she claimed she had been following at home.

In contrast to the previous patient this one received blood and no ether but the result was the same. Patients with any appreciable degree of the pathology found in either the kidney or liver seldom survive for long. The combination is far deadlier. So great is the current interest in electrolytes that anyone signing a death certificate in a case of this kind without mentioning them, like the teenager without braces on her teeth, feels sort of out of things.

Case No. 208. I am inclined to agree with the reviewer who thought this patient was overtreated and overstudied. This last term is new to me but I think it is a good one. It seems to me that the dosage of barbiturates and narcotics was pretty steep although I've never been suspected of Homeopathic tendencies. It seems to me that the most significant laboratory finding was the CO_2 and yet the treatment of the acidosis seems to have been pretty casual.

Failure to do a cesarean section during the anuric period may or may not have been a mistake but it is very doubtful that anything would have altered the outcome and the attending physician anymore cannot always use his own best judgment. He has to keep one eye cocked on the consultation requirements of the accreditation boards and the other on the maternal mortality survey board. He is apt to proceed with caution under such circumstances when boldness may well be what's called for.

Back about 1938 in *The Journal of the American Medical Association,* Nelson made a very good case for the use of large quantities of water where the concentrating power of the kidney was low but his suggestions probably would not be applicable in the face of almost complete anuria.

Milk-Alkali Syndrome with Jaundice and Tetany

Hypercalcemia and the accompanying calcinosis is not peculiar to the milk-alkali syndrome, yet hypercalciuria is not generally found. The fact that urinary excretion is not excessive suggests some interference with the renal excretory mechanism. Alkalosis, almost invariably present, probably plays the most important role in initiating the kidney impairment. It has been demonstrated that urinary calcium clearance is diminished by alkali administration, and Burnett and his associates showed significant reduction of renal clearance mechanisms resulting from alkalosis subsequent to pyloric obstruction. Upon correction of the alkalosis, decided improvement was manifested, leading to the suggestion that this renal insufficiency resembles, in some respects, lower nephron nephrosis. Renal failure associated with hypercalcemia has been observed in hyperparathyroidism, myelomatosis, vitamin D intoxication, skeletal immobilization, sacroidosis and carcinomatosis with generalized bone involvement. Yet the hypercalcemia and renal failure in the milk-alkali syndrome will not likely arise from excessive calcium intake alone unless alkalosis is also present.

The kidney deterioration may be furthered by the hypokalemia frequently associated with alkalosis. In addition to the gastrointestinal loss, the high serum bicarbonate facilitates the transfer of potassium from the intracellular compartment and the entrance of sodium into the cell. Additional potassium loss is incurred by the inability of an already impaired kidney to conserve potassium. In a report of one other case in which muscular twitching was present, the author expressed the belief that hypokalemia was crucial in the causation of the metabolic alkalosis and the genesis of the milk-alkali syndrome.

Elevation of the pH, of serum sodium and potassium ions may result in heightened muscle excitation. . . .

Confusion in the differentation from primary renal disorders is to be anticipated in this syndrome, yet infrequently in cases reported is there suggestive evidence of previous renal disease. The changes expected with chronic nephritis—metabolic acidosis, hypocalcemia and hyperphosphatemia—are not present. Further, the rapid reversal of the azotemia and the renal failure pattern as soon as the ingestion of the alkali and milk is discontinued, probably gives the most impressive clue to the proper diagnosis of this syndrome. The serum calcium may fall to normal levels within one to two weeks.—Abraham A. Goetz, M. D., Sunnyvale, Calif.: *California Med.,* 89:136, Aug., 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS was the first University Hospital (Columbus) admission of this 41 year old white male, who complained of severe shortness of breath over the past two years. The patient had measles and whooping cough in childhood, but neither disease was complicated by pulmonary symptoms. He had his first attack of pneumonia at the age of 12 years. Between the ages of 9 and 27 years he worked on a farm doing mostly baling and threshing, and was so bothered by the dusty atmosphere that he wore a dust mask for a time. He changed his job to driving a milk truck but noted shortness of breath, especially when lifting milk cans.

At the age of 32 he had a second attack of pneumonia, following which he spent eight months in Tucson, Arizona. At the age of 40 he was hospitalized for two weeks for his third attack of pneumonia and during this hospitalization he required continuous oxygen administered by an oxygen tent. Ten days later he was readmitted for treatment of a ruptured appendix. During this hospitalization he required intermittent oxygen and from then on he required oxygen intermittently for six months, after which he was on continuous oxygen administration.

Recently he had been using Isuprel® in a nebulizer with some temporary relief. He was also on Delta Cortef,® 5 mg. two or three times daily; Diamox®, 250 mg. in the mornings from time to time; and Equanil,® 400 mg. four times a day.

Blurring Vision

In the three weeks prior to admission he noted relatively rapid blurring of vision, which progressed to the point that he was unable to recognize individuals clearly. He had a chronic cough productive of small amounts of yellow sputum over unspecified periods of time, and had been troubled with frequent frontal headaches which occurred most often in the evening. During the hospitalization for his third attack of pneumonia he developed epigastric pain relieved by food. A duodenal ulcer was demonstrated by x-ray at that time and he had been on special diet since. He never gave a history of gastrointestinal bleeding. He had had nocturia of 6-7 times for an unspecified period; however, he had had no dysuria. The patient had no known allergies. He had smoked two packages of cigarettes daily for many years. His family history was inconsequential.

Presented by

- **Wiley Forman, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Physical Examination

The patient appeared in severe respiratory distress, was sitting on the edge of the bed and wearing an oxygen face mask. His skin was cool, moist and pale. His blood pressure was 120/80, his pulse 100 and his respirations 12. His chest was barrel-shaped with a considerable increase in the anteroposterior diameter. It showed marked respiratory retraction of the supraclavicular and intercostal spaces with little respiratory movements of the bony thorax. His chest was hyperresonant and the breath sounds over the right lateral chest had a bronchial quality. There were inspiratory wheezes over the right upper lung field.

The examination of the heart showed normal sinus rhythm without murmurs; the estimation of the cardiac size proved difficult. The abdomen was tense and difficult to palpate, but the liver and spleen were not palpable. The mid-epigastric region was tender. No peripheral edema or peripheral vascular abnormalities were observed. The neurological examination was not remarkable.

Laboratory Tests

Examination of the urine was essentially negative. He had a red blood count of 2.35 million, a hemoglobin of 5.4 Gm., and a mean corpuscular hemoglobin concentration of 25 per cent. His white count was 7,900 with 81 per cent polymorphonuclear leukocytes, 15 per cent lymphocytes, 2 per cent eosinophils and 2 per cent monocytes. His blood urea nitrogen was 19 mg. and his fasting blood sugar 104 mg. The serologic test for syphilis was negative. The radioactive iodine uptake was 8.4 per cent in 24 hours and excretion of

radioactive iodine in the urine was 62.5 per cent in 24 hours.

X-Ray Examination

His chest showed marked generalized emphysema with several radiolucent areas in the left middle and lower lung fields suggestive of emphysematous blebs. There was dense fibrosis involving the lower two thirds of the right lung field probably associated with chronic inflammatory changes. There was also a circumscribed area of density in the left lung near the lingula. The upper lung fields appeared essentially clear. The pulmonary artery was prominent.

Hospital Course

On the fourth hospital day the patient had periods of apnea and unresponsiveness during the early hours of the morning. However, his general condition remained unchanged. The marked hypochromic anemia suggested the possibility of a recurrent peptic ulcer with hemorrhage. However, several stools were guaiac-negative and he was free from abdominal symptoms. After 2 units of whole blood his hemoglobin rose to 7.1 Gm. and he appeared more alert. The fifth day he received a third unit of whole blood and was under continuous oxygen. However, in the evening he was found again unresponsive with a weak pulse of 132 per minute, a blood pressure of 60/0, and very irregular respirations.

After 1000 cc. of 5 per cent dextrose with 4 cc. of Levophed®, his blood pressure rose to 120/80 and stabilized at 100/70. He received another 2000 cc. of dextrose with Levophed and 1000 cc. of whole blood, but did not rally. His systolic blood pressure remained between 80 and 120, his pulse varied between 120 and 130, and his respirations were irregular and very shallow. By early morning of the sixth hospital day the patient's blood pressure and respirations slowly fell to zero and he expired. Other therapy given during the last 36 hours included Combiotic® and Pro-Banthine.® His temperature remained normal throughout his hospital stay.

Clinical Discussion

DR. WILEY FORMAN: Significant in the story of this 41 year old white male was his complaint of shortness of breath for the preceding two years. He had an antecedent history of having had at least three attacks of what has been termed pneumonia. It may or may not be significant that he worked for about 20 years in a barn where the dust bothered him so much that he wore a mask. The history does not state whether he had typical attacks of asthma or whether he was just bothered with bronchial irritation, but it forced him to give up his job. After a second attack of pneumonia at the age of 32 he spent eight months in Arizona, presumably at the request of his doctor "to improve his lungs." Apparently it did not do him too much good, since his dyspnea became steadily worse, although frankly I am just assuming this since it is not stated specifically in the history.

During his hospitalization for his third attack of pneumonia, and later for his ruptured appendix, he required oxygen, and he kept up this oxygen intermittently for about six months. He was treated then with the usual medications for pulmonary insufficiency, asthmatic bronchitis, or chronic pulmonary infections: nebulizers, steroids and tranquilizers. Cough is significantly absent from his protocol and is only mentioned as having been present for an unspecified period of time. I do not quite understand the blurring of his vision and his frontal headaches and whether the latter was caused by his eye troubles or by paroxysms of coughing with increasing respiratory distress. Just to complicate the picture, he developed ulcer symptoms and was put on some sort of Sippy diet with antacids, etc.

Emphysema

His chest certainly was that of a markedly emphysematous individual who also had some evidence of infiltration in his right middle lobe. The heart size apparently was difficult to percuss with his emphysematous chest but seemed otherwise normal. The abdomen was not remarkable. The slight tenderness in his epigastrium could be possibly associated with his duodenal ulcer.

His blood count showed a hypochromic anemia, which was the reason why he was not cyanotic. His white count showed a shift to the left. From his x-ray studies one would say that he had evidence of an outstanding pulmonary emphysema, pulmonary fibrosis, chronic infiltration on the right as well as on the left, and that there was some question whether the infiltrate was inflammatory or carcinoma. He had no enlarged mediastinal nodes, and these translucent areas probably represented cystic bronchiectasis. We know that people with bronchiectasis are likely to be expectorating much more sputum than this patient, but we have to accept the facts we have here before us.

I can't let this opportunity go by without making comments about several studies that I think were indicated. There was no mention here of any sputum studies whatsoever, and as glibly as we order electrolytes in this hospital, the one case where we would really like to see them has no data about blood chlorides, CO_2 or sodium. He lived in the hospital only about six days and

I suppose he was not in any shape to have pulmonary function studies done. They might have been quite revealing and confirmed the clinical impression that this patient had a chronic pulmonary disease, inflammatory in nature, with emphysematous blebs and asthmatic bronchitis, and that he was developing with his shortness of breath and dependency upon oxygen more and more symptoms referable to pulmonary insufficiency.

On his fourth hospital day, when he was still sucking up his oxygen as greedily as ever, he began to have periods of apnea and unresponsiveness. By the fifth day he was requiring still more oxygen, and something happened then and he died within a period of about 24 hours. His lungs appeared clear at this time, but his heart sounds were poorly heard. He had no appearance of peripheral shock and no evidence of acute blood loss. In spite of the usual emergency medications, Levophed and blood, he died.

The Cause

So we might ask ourselves first, what was initially the cause of his chronic inflammatory pulmonary disease which was complicated by what we presume to be asthmatic bronchitis, pulmonary fibrosis and emphysema? In this instance one may have to go back to the hayfield. He had had 20 years of exposure to farm dust in which there may have been spores of timothy, and according to the English literature these small fragments may plug up the alveolar ducts and small atelectatic areas appear in the lungs, followed by small blebs, emphysema, infection, and finally chronic pneumonitis with the clinical picture of asthma or asthmatic bronchitis depending on how much infection is superimposed.

This patient probably experienced what has been called a restrictive ventilatory pulmonary insufficiency as opposed to obstructive forms of pulmonary insufficiency. That is to say that there is something at the level of the pulmonary alveolar membrane which interferes with gaseous exchange. That is more likely to be explained on the basis of fibrotic pulmonary disease. On the other hand, if there are asthmatic symptoms with a bad lung, then there is more likely to be obstructive ventilating pulmonary insufficiency. These can be differentiated as you know by the presence or absence of expiratory wheezes on careful auscultation.

One might further ask what brought about his chronic pulmonary inflammatory disease which we think he had? I think it is probably nonspecific. I am at a loss to find any mycotic diseases that appear specifically in hay. In the *British Medical Journal* there were recently described 10 cases of "farmers' lung" and no specific mycotic infection was found. I don't think the patient had the picture of histoplasmosis, and I am inclined to dispose of other dust-borne molds—actinomycosis, blastomycosis, coccidiomycosis, etc.—because he lacked the rest of the clinical picture of adenopathy, skin lesions and other visceral manifestations.

Why did this man have anemia? There are several things that come to my mind. One is that a longstanding pulmonary infection might outweigh the mechanical effects of his pulmonary insufficiency and lead to anemia rather than to polycythemia with clubbing and pulmonary osteoarthropathy. Blood loss might account for his anemia, but none was found in this patient. Then a state of malnutrition might account for it. A certain percentage of people who have chronic pulmonary diseases of this variety get so sick and feel so badly that they simply don't eat and instead of being polycythemic they have a nutritional type of anemia.

And finally, this disease may be complicated by cancer of the lung. If he had cancer of the lung one might more easily accept the fact that he had headaches for several weeks prior to admission and that his vision blurred to the point where he could not recognize people while his fundi and his neurological findings were negative. Personally I simply mention these possibilities to get rid of them.

Cerebral Hypoxia

The next question which bothered me also was why he had blurred vision and headache. I think that the most logical reason is that this man was experiencing marked cerebral hypoxia. We have not enough information on the chart to confirm this opinion, no elevated carbon dioxide with low blood chlorides and changes in the *p*H, but the natural clinical course of these people explains such episodes. I think that this is probably the explanation for his headache, although it may be that he was coughing more than we realize and that may be part of the picture. I mentioned metastatic carcinoma. I don't think he had it. I mention metastatic infection to the brain. If he had a brain abscess I would not expect him to show this clinical picture and I am inclined to omit this diagnosis also.

Why then did he die? Over the years, and particularly over the preceding six months, he was using more and more oxygen (obviously he was hypoxic and needed it), and as long as he was not put in the hospital he got along pretty well. But his pulmonary disease was getting worse and worse and then he had oxygen rather continuously and it was turned up more and more. The only stimulant that his respiratory center is

getting from his mild anoxia, which he is able to tolerate and live with, is being destroyed by giving him more oxygen, and consequently he goes into central nervous system depression and that is the end of it. Instead of relieving him you make him worse. So I think that this patient died from decompensated respiratory acidosis.

In summary then, Dr. von Haam, I think this man did have chronic pneumonitis with severe fibrosis, that he had severe pulmonary emphysema with bleb formation, and that he had asthmatic bronchitis. I put down cor pulmonale, which I think was not too great a problem if the record is correct. I can't help but put down carcinoma of the left lung with metastasis, with a question mark. The protocol is insufficient for me to come to that conclusion. I think he had some minor other disease associated with it leading to secondary anemia. I think his immediate cause of death was cerebral hypoxia due to pulmonary insufficiency, and oxygen intoxication which really means carbon dioxide narcosis.

Clinical Diagnosis

1. Pulmonary fibrosis with severe emphysema.
2. Chronic asthmatic bronchitis.
3. Cor pulmonale.
4. Carcinoma of the left lung (?).
5. Chronic duodenal ulcer.
6. Secondary anemia.
7. Oxygen intoxication.

Pathological Diagnosis

1. Pulmonary fibrosis with severe emphysema.
2. Subacute bronchitis.
3. Cor pulmonale.
4. Pulmonary hemorrhage, old and recent.
5. Gastrointestinal hemorrhage.
6. Secondary anemia.

Pathological Discussion

DR. VON HAAM: The body was well developed and well nourished. The heart was enlarged and universally dilated. The right ventricle measured 4 to 5 mm. in thickness. The lungs were quite heavy and filled with dark-red foamy edema. They were diffusely emphysematous with blebs scattered throughout the lung tissue. Both lung bases showed areas of nodular consolidation. There was no grossly demonstrable bronchiectasis. The stomach contained 500 cc. of coffee-ground material which came from numerous small bleeding spots. No ulcer was found. Tarry material was also present in the small bowel. The adrenals were extremely small and had a combined weight of only 11 grams. Permission was not obtained for autopsy of the brain.

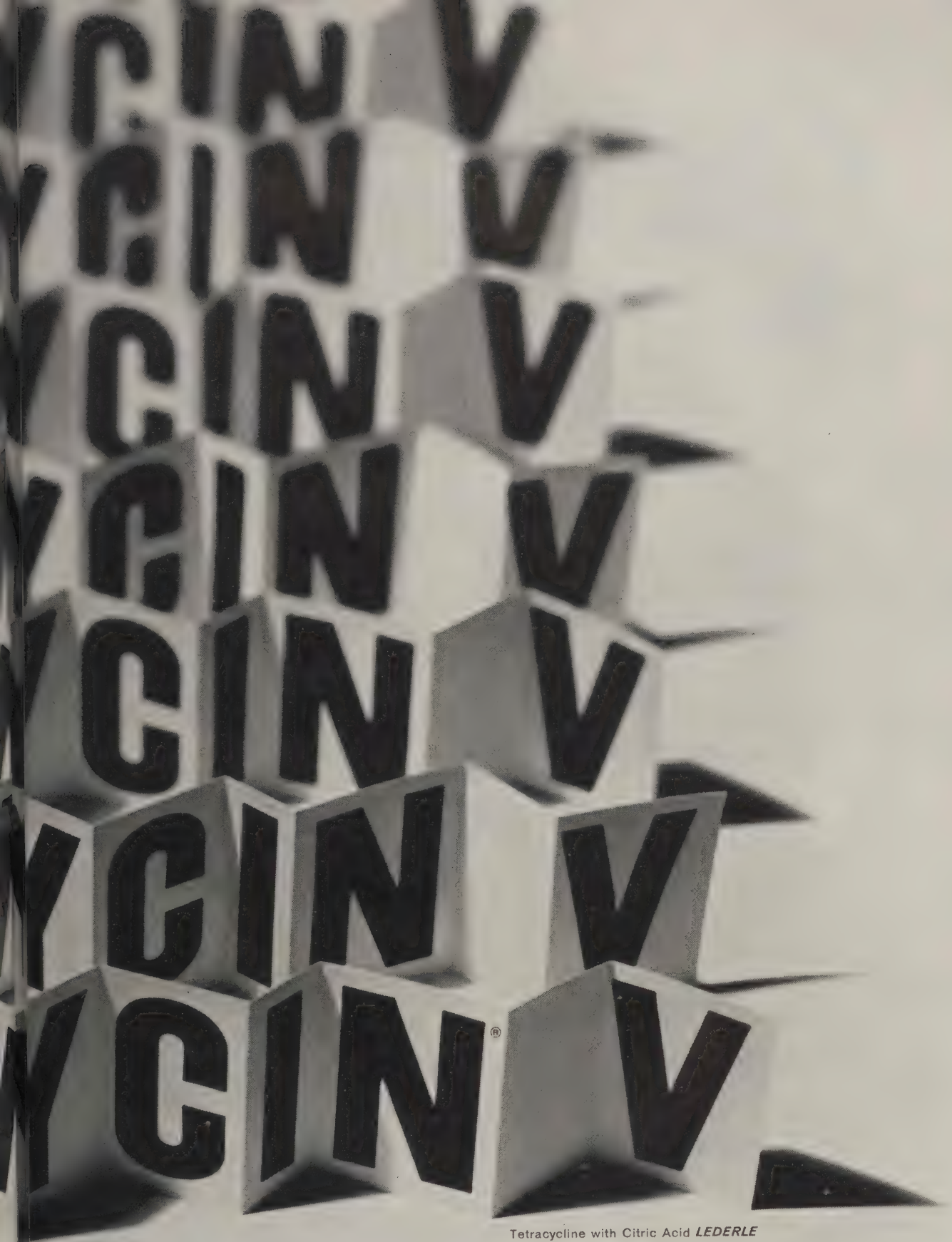
Microscopic Examination

Sections through the lungs showed a very severe emphysema. Scattered throughout the emphysematous areas there was a diffuse and patchy pulmonary fibrosis. The small bronchioles appeared distended and filled with pus. With high magnification numerous unidentified dust particles could be noticed in the fibrotic areas. The dust was negative when tested for silica, beryllium or asbestos. There were only a few areas of acute pneumonic infiltration with few bacterial colonies. Special stains for fungi and tuberculosis bacilli were negative. Examination of the stomach and esophagus showed multiple hemorrhagic erosions but no evidence of peptic ulcer. Liver sections gave the picture of acute congestive failure with the formation of central lobular blood lakes and liver cell degeneration. The adrenal glands showed a remarkable cortical atrophy. The bone marrow showed a moderate degree of erythroid hyperplasia.

In summary, I feel that the patient had an obstructive type of emphysema caused by pulmonary fibrosis and chronic bronchitis. He also had evidence of acute adrenal insufficiency probably caused by the prolonged administration of cortisone. The heart changes can be explained by the combined effect of a chronic anemia and the increased resistance of the pulmonary circulation. I do agree with Dr. Forman that cerebral anoxia can produce all kinds of early neurological symptoms, and simple auricular fibrillation may give the clinical picture of a stroke. The point with regard to the oxygen intoxication is quite interesting. How do you think the oxygen hurt him and, how should this patient have been handled?

DR. FORMAN: Oxygen intoxication is being recognized more and more as a dangerous complication in this type of patient. If they receive it continuously, they will die from respiratory anesthesia. They do not tolerate continuous oxygen but must get it intermittently in order to prevent paralysis of the respiratory center. In cases of progressive pulmonary fibrosis it is important to prevent if possible any additional pulmonary infection, to keep the secretions from becoming too tough and tenacious, and to try to alleviate the great anxiety of these patients so that they can learn how to breathe better. It is very important to use as little oxygen as possible and to give it intermittently.


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Red Letter Dates

For Your 1959 Calendar

It isn't too early to make Hotel Reservations Now for the 1959 ANNUAL MEETING of the OHIO STATE MEDICAL ASSOCIATION. The place is COLUMBUS: the dates, APRIL 21, 22, 23 and 24.

Here is a list of leading downtown Columbus hotels and a hotel reservation blank for convenient mailing.

NAME AND LOCATION	SINGLE	DOUBLE	TWIN
NEIL HOUSE, 41 S. High St.	$ 5.50- 9.00	$ 9.00-11.00	$11.00-14.00
DESHLER-HILTON HOTEL, W. Broad & N. High	$ 7.50-14.00	$12.00-15.00	$12.00-20.00
PICK-FORT HAYES HOTEL, 31 W. Spring St.	$ 7.00- 8.00	$10.00-10.50	$11.00 up
SENECA HOTEL, 361 E. Broad St.	$ 4.00- 6.00	$ 7.00- 9.00	$ 9.00-12.00
HOTEL SOUTHERN, S. High & E. Main Sts.	$ 6.50- 7.00	$ 8.50- 9.50	$11.00-12.00
VIRGINIA HOTEL, Gay & Third Sts.	$ 6.00- 8.00	$ 9.00-11.00	$12.00-15.00

Persons who desire additional accommodations are advised to specify their needs to the hotel of choice.
(All Rates Subject to Change)

HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager ..... Columbus, Ohio
(Name of Hotel)

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 21-24, 1959, or for such other period as may be indicated herein.

☐ Single Room with Bath ☐ Double Room with Bath Price .....

☐ Twin Bed Room with Bath ☐ Other

Arriving April ..... at .....A. M..... P. M.

PLEASE VERIFY MY RESERVATION

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Social Security Poll Results . . .

Members Totaling 4,095 Vote for Inclusion of Physicians; 2,737 Against; Ballots Mailed in by 76 Per Cent of State Association's Membership

IN a poll taken by mail during the month of October, 4,095 of the 8,960 members of the Ohio State Medical Association voted in favor of the inclusion of physicians in the Federal Social Security Program.

Members of the Association voting against the proposal, "Should Physicians Be Included in the Federal Social Security Program?," totalled 2,737.

Yes Vote 45.7% of Membership

Marked ballots were received from 6,832 members—76 per cent of the total membership of the Association. Fifteen unmarked ballots were received.

Those voting in the affirmative composed about 45.7 per cent of the total Association membership.

Up To Congress

Doctors of medicine are the only major self-employed group in the nation not covered under the Old Age and Survivors Insurance section of the Social Security Program. Proposals to remove that exemption have been before the U. S. Congress during the last several sessions of the Congress.

The Ohio State Medical Association poll was conducted as a result of a resolution adopted by the House of Delegates at the 1958 Annual Meeting in Cincinnati last April. The resolution read as follows:

Text of Resolution

WHEREAS, The inclusion of doctors of medicine in the Federal Social Security program is currently under consideration, and

WHEREAS, The Ohio State Medical Association and the American Medical Association are now on record as opposing the inclusion of physicians in the Social Security program, and

WHEREAS, A considerable number of physicians in Ohio have expressed a desire to be included in the Social Security program, and

WHEREAS, It is desirable to ascertain the current sentiment of all members of the Ohio State Medical Association on this question.

THEREFORE BE IT RESOLVED, That (1) the individual members of the Ohio State Medical Association be polled by the Association on the question as to whether they favor or oppose the inclusion of physicians in the Federal Social Security program, and (2) the results of this poll showing the number of votes in favor of and in opposition to such inclusion be made a matter of record and transmitted to the House of Delegates of the American Medical Association, and

BE IT FURTHER RESOLVED, That such poll be conducted prior to the 1958 interim session of the American Medical Association so that the results of such poll can be submitted to the House of Delegates of the American Medical Association at said meeting.

Ballots were sent to all members of record on October 1, 1958. Prior to that time many articles pro and con on the subject had been published in the July, August and September issues of *The Ohio State Medical Journal*. References to the poll were made on several occasions in the *OSMAgram* before the ballots were distributed.

Committee of Tellers

Counting of the ballots and tabulation of the results took place on November 5. A special committee had been appointed by Dr. George A. Woodhouse, President of the Association, for that assignment. It was composed of three Columbus members of the House of Delegates of the Association, namely, Dr. Robert M. Inglis, chairman, Dr. Perry R. Ayres and Dr. Philip B. Hardyman. Official announcement of the poll results was made by Dr. Woodhouse on November 7, following receipt of a report from Dr. Inglis.

Results of the Ohio poll will be transmitted to the House of Delegates of the American Medical Association by Ohio's delegates at the Minneapolis interim session of the AMA, December 2-5.

Present Policies

At present the official policies of the Ohio State Medical Association and the American Medical Association on inclusion of physicians in the OASI program, as established by their respective House of Delegates, are against the inclusion of physicians. In the past several years, resolutions which would rescind that policy and set up a policy in the affirmative have been introduced in both houses but have not been adopted.

Industrial Eye Problems

Industrial Eye Problems, a four day course in eye care and industrial eye programs will be presented by the Institute of Industrial Health and the Department of Ophthalmology of the University of Cincinnati on March 9-12, 1959. The course will be open to physicians only with preference given to men in active industrial practice.

Additional information may be had from the Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenue, Cincinnati 19, Ohio.

APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1959 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, O., APRIL 21-24

1. Title of Exhibit: .....

2. Name(s) of Exhibitor(s): .....

.....

Institution (if desired): .....

City .....

3. Description of Exhibit: **(Attach 200 word description to this blank)**

4. Exhibit will consist of the following: (Check which)

Charts and posters..... Photographs..... Drawings..... X-rays.....

Specimens..... Moulages..... Other material.....
(Describe)

5. Booth Requirements:

Length of back wall needed? .....

Square feet needed? .....

Shelf desired? (yes or no) .....

6. Transparency Cases:

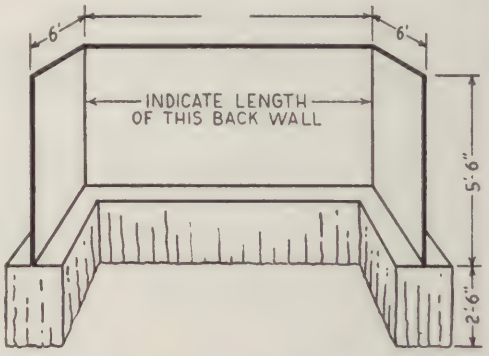
Needed? (yes or no) .....

If answer "yes," give following information:

Number of transparencies to be shown and size of each .....

.....

.....



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association."

Date .....

.....
Signature of Applicant

.....
Mailing Address, Street

.....
City, Zone, State

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO

Health Commissioners Act . . .

Score of Endorsements and Recommendations on State and Local Services Get the Approval of Commissioners at the Recent Conference in Columbus

OHIO'S health commissioners, at their 39th annual conference in Columbus on September 12, endorsed the Ohio State Medical Association's efforts to upgrade the performance of medical technology and evaluation of laboratories.

Addresses by OSMA President George A. Woodhouse and Dr. Ralph E. Dwork, state director of health, at the conference appear elsewhere in this issue of *The Journal*.

Other endorsements and recommendations voted by the health commissioners included the following:

Meat and Milk Proposal

A meat and milk hygiene program proposed by the Ohio State Veterinary Medicine Association; voluntary certification for sanitarians; licensing procedures and regulations for plumbers; placing of general health districts under civil service.

Continued study of the migrant labor problem in Ohio; minimum $20,000 a year salary for the state health director; legislation to provide for tuberculosis hospital conversion, financing and, if the situation merits, closure of such hospitals.

Funds To Be Asked

Classification of staphylococcal lesion occurring in the newborn period (first six weeks) as a reportable disease; appointment of a committee to study Ohio's school health laws for evaluation and recommendation at the 1959 conference; study of the problem of seeking additional legislative appropriation for expansion of the rheumatic fever program; legislative appropriation for training personnel to be used in health departments for providing increased and better services for infirmed aged.

Close adherence by local health departments to policies on vision conservation programs in schools recommended by the Vision Conservation Advisory Board to the Ohio Department of Health; provision of a copy of the recommended vision conservation program for all local health commissioners.

Back Air Pollution Control

Request that the State Health Department seek funds from the Legislature for implementation of an air pollution control program; establishment of a better industrial hygiene program in local areas; development of a plan for adequate and safe disposal of x-ray shoe-fitting machines; better liaison between the ODH's Nutrition Unit and the Ohio Department of Education in administrative supervision of school health programs.

Appointment of a committee to investigate and report back to the conference as to the responsibility of local health departments in the processing, distribution and safeguarding of food products; the expansion of the ODH Nutrition Unit's services as rapidly as possible.

Ohio Auxiliaries Getting Ready for 1959 AAPS Essay Contest

Local units of the Woman's Auxiliary to the Ohio State Medical Association are being asked again to sponsor the 1959 National Essay Contest of the Association of American Physicians and Surgeons. The contest has the approval of the House of Delegates of the Ohio State Medical Association which recommended that the auxiliaries sponsor the contest.

Entries in the contest may be written on either of the following subjects: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." The competition is open to all ninth, tenth, eleventh and twelfth grade students.

Last year over 300 essays were submitted from Ohio. In the National judging, Miss Jane Litzinger of Somerest, Ohio, received the eleventh prize, while Miss Janet Holshoy of Massillon, Ohio, placed thirteenth.

Dr. George H. Lemon, Toledo, is the Ohio essay chairman. He has sent essay information and package libraries to the presidents and secretaries as well as to the Public Relations Chairmen of all the local auxiliaries.

State prizes to be offered will be $100 for first place, $50 for second place, and $25 for third place. The winning state entries will be submitted for competition in the national judging. The national first prize is $1,000 with 13 additional prizes being offered.

Commenting on the contest, Dr. Lemon said: "This essay contest is important to every doctor and to all businessmen because it stimulates the high school children of this state and nation to investigate the values of private medical care and free enterprise. We urge every doctor to cooperate with the Woman's Auxiliary of his area to encourage the greatest participation possible."

Cooperation Essential . . .

OSMA President Calls for Physicians in Private Practice and Health Commissioners To Work Together Toward Solution of Mutual Problems

FOLLOWING is the text of the address of Dr. George A. Woodhouse, president of the Ohio State Medical Association, at the 39th Annual Conference of Ohio Health Commissioners with the Ohio Department of Health, in Columbus on last September 11.

* * *

It is a delightful experience for me to be invited to address your conference as a representative of the more than 9000 doctors of medicine who are members of the Ohio State Medical Association. I have been told that this is an annual occasion when the President of the Medical Association has the opportunity of making this address and thus the opportunity of further cementing the activities of our two organizations.

Objectives of OSMA

The first words printed in the Constitution and By-Laws of the Ohio State Medical Association are: "The purposes of this Association are to promote the science and art of medicine, and the protection of public health." Thus the founding fathers of organized medicine in Ohio realized over one hundred years ago the necessity of their participation in the affairs of public health. It still is one of our major objectives. The activities of both your department and the Ohio State Medical Association are cemented into one bulwark of defense in the matter of public health.

The control of the communicable diseases in the United States, and more particularly in Ohio, further connotes the activity of the two organizations. In 1900 the three leading causes of death, as an example, were all diseases of a communicable nature: pneumonia and influenza; tuberculosis; and diarrhea and enteritis. These three disease groups, with a combined death rate exceeding 500 per 100,000 population, accounted for nearly a third of all deaths. By 1956, with corresponding death rates per 100,000 of around 28, 9 and 5 respectively, the combined rate from these diseases had dropped to just over 40, or less than one-twentieth of all deaths. Mortality from most other communicable diseases had also been brought to exceedingly low levels and in some cases almost eliminated. It is particularly interesting to note in all the statistics presented to date the diminishing hazards of infancy, even with the tremendous rise of population; and while the population as a whole has benefited by the cooperative activities of public health officials and practicing physicians, the children and young adults have benefited the most in this mortality reduction.

Progress Brings New Problems

Continuing progress in medicine and public health will undoubtedly bring further reductions in mortality from pneumonia, influenza, and tuberculosis. Yet these diseases cannot be considered conquered as long as new cases are reported in large numbers. Progress itself brings new problems. For example, a rising proportion of tuberculosis patients are being treated with drugs, without long hospitalization; but these patients require careful medical and other supervision at home.

Against influenza, newly developed vaccines have had considerable effectiveness thus far. Much has been accomplished, especially in international cooperation in reporting new epidemics and in identifying the strain of the virus responsible. Nevertheless, effective control measures have not yet been evolved against all strains of the virus. Thus the further progress of public health activities is demonstrated in this air age of global responsibility.

The communicable diseases continue to represent a major challenge to medicine. The virus diseases especially, about which relatively little is yet known, bear special watching. Serious problems have been raised by the emergence of antibiotic-resistant strains of bacteria. Ultimately, however, the communicable diseases may become nothing more than an episode in man's history.

Role of Both Groups

I think that it might be well to discuss for a short period the role of the Public Health Official and that of the Practitioner of Medicine. In the application of public health, it takes one who treats the individual as a community and another who treats the community as an individual, to make progress in this field. The private practitioner has responsibilities in prevention, and consequently with mass disease and public health. The Public Health physician has a long line of responsibility in epidemiology and health education. He therefore wisely stays out of the field of individual

treatment. Today the well-qualified public health leader must have medical training. In addition, he must be trained in group leadership, in administration, in handling of budgets, and in the application of educational measures to persuade the public to support actions beneficial to both individuals and whole communities.

Although some physicians and some medical societies have been charged with disinterest in public health, it is my belief that more and more of them are showing real concern for the well-being and betterment of their home towns. Certainly the success of public health programs depends to a large degree upon the practicing physicians, and other medical personnel and medical facilities in the community. A health department unsupported by the medical profession, divorced from the community hospitals and alienated from others in the community working towards the same goals, is indeed a sorry thing.

Should Get Together

I will admit that there have been times when the medical profession has been heard only when it criticised or opposed certain health programs which the profession believed to be unwise or impractical. However, the blame may not necessarily be on one side. It may be that the health officer went ahead on his own without adequate consultation. It may be that the medical profession was not kept informed of the reasons for the program and how it would operate. Regardless of who is to blame, the situation has been deplorable in that most differences have been unnecessary. We must eliminate rivalries and controversies which do immeasurable harm to our cause and bring public discredit upon both of us.

Fortunately, conditions such as I have described are few and far between here in Ohio. A spirit of cooperation between the Ohio State Medical Association and The Ohio Department of Health has existed for many years. I can't possibly name all who have had a part in this, but I would like to thank your present Health Director, Dr. Ralph Dwork, and his immediate predecessor Dr. John Porterfield for their help and cooperation. The Health Department has had problems, many of them major in nature. The Ohio State Medical Association has also had problems. How have these problems been approached? By cooperation and discussion around the table with our Council and committees.

Food For Thought

I have read with much interest the activities of the Ohio Department of Health in the magazine, *Ohio's Health,* May 1958 issue. The article, "Highlights of 1957," has given me and I am certain the other doctors of Ohio much food for thought. To myself it is amazing the work that has been done on a restricted budget, and I do know how much that budget was restricted. The heading of some of the articles tell an amazing story. Some of them are: "The Cost of Living," "Treatment Patterns are Changing," "Cases Harder To Find," "Staphylococcal Disease of The New Born," "Polio Continues Downward," "Asian Flu Appears," "Long Term Illnesses," "Diabetes and Rheumatic Fever," finally "Community Must Be Receptive," and many others. I congratulate you on your efforts.

New OSMA Activities

In conclusion, I would like to point out to the members of the Conference three new activities of the Ohio State Medical Association, authorized by the last session of our House of Delegates in Cincinnati. They are the formation of three new committees, namely, Committee on Care of the Aged, Traffic Safety Committee, and Poison Control Committee. Each of these committees is concerned with problems of Public Health in Ohio.

The Committee on Care of the Aged is a new one. It will study the problems of the aged and cooperate with similar work being done on a national level by the A. M. A., the American Hospital Association and other national groups, and with various State and local organizations and agencies, including Public Welfare and Public Health agencies. This is a long-term project which will require much work and cooperation.

The Traffic Safety Committee was formed after my suggestion that the rising number of deaths from highway accidents, together with the jamming of our hospitals with victims of such accidents, produce a problem which warrants the cooperation and study of a major committee of our organization. It is designed to implement the Traffic Safety program in Ohio being carried out by the Department of Highway Safety, the State Highway Patrol, and the Ohio Committee on Trauma of the College of Surgeons. This committee has had its first organization meeting, and is now functioning.

The Poison Control Committee will investigate the possibility of establishing a 24 hour-a-day single poison control center for all Ohio, or setting up area poison control centers in the state to help combat the rising tide of accidental poisonings from many brand name chemical products used in the home, on the farm and in industry. It has not been decided as to which plan would be most feasible. A statewide educational program, the study of possible state legislation for a uniform

labeling of such products, and efforts to secure the cooperation of all organizations in the field of health and safety in developing a comprehensive statewide poison control program, will be undertaken by our committee.

Local Cooperation Essential

I have pointed out the cooperative spirit enjoyed by your State Director and his staff with the governing body and committees of the Ohio State Medical Association.

To you who are health officers of our counties and cities, I urgently recommend that you endeavor to build up the same kind of cooperation with your respective county medical society. Since cooperation is a two-way street, obviously, I strongly advocate that each of our county medical societies meet you at least half way.

I have been informed that in some counties, the local health officer, or officers, rarely attend a county medical society meeting.

On the other hand, I am advised that in some counties, it is difficult to get a physician willing to serve on the board of health, or to attend board meetings after he takes the assignment.

These situations must be corrected. If public health work in Ohio is to become really as effective as it should be, these conditions must be eliminated. It is time for the medical profession and the health officials in areas where these situations exist to draw up their chairs to the conference table and try to solve these, as well as other problems.

Again, Dr. Dwork and members of the conference, I wish to thank you for extending to me this opportunity to discuss some of our mutual problems. It is a gratifying relationship which I hope will continue indefinitely.

Today's Children Taller and Heavier Than Those of Last Generation

Today's children are taller and heavier than those of a generation ago.

Comparison of measurements for Michigan children made recently with those in 1937-1939 shows consistently higher figures for today's children. Among boys under 9, average heights were greater by a fraction of an inch, and at ages 9 and over by an inch or more. Among girls the difference was an inch as early as age 8. The increase in average weight ranged from more than 2 pounds at age 7 to as much as 13 pounds at age 14.

Similar trends for the average heights and weights of elementary school children are evident elsewhere in this country and in Great Britain and the Commonwealth countries.—*Metropolitan Life.*

Ohio Society of Internal Medicine To Coordinate Meeting with College of Physicians

The annual meeting of the Ohio Society of Internal Medicine will be held Wednesday, January 21, 1959, at 8 p. m. at the Netherland Hilton Hotel, Cincinnati. The presiding officers will be Dr. Arnoldus Goudsmit, Youngstown, president; Dr. Geo. J. Hamwi, Ohio State University, Columbus, vice-president; Dr. Leonard P. Caccamo, Associate of American College of Physicians, Youngstown, secretary-treasurer.

The annual meeting will be devoted to a review of the progress made by the Society in the interest of patient care requiring the specialty of internal medicine, in the State of Ohio during the year 1958. Plans for the activities for the coming year will be proposed and committee reports from a special liaison committee with Ohio Medical Indemnity, Inc. The membership will also be requested to consider a change of the by-laws of the organization. As has been the custom in the past, Dr. Arnoldus Goudsmit will deliver a presidential address.

A special feature included in the annual meeting this year will take place the following day in cooperation with the Ohio Regional Meeting of the American College of Physicians. Dr. A. Carlton Ernstene, governor of the College for Ohio, has invited the Ohio Society of Internal Medicine to take part in the program of the Regional Meeting. The Ohio Regional Meeting of the American College of Physicians will be held on Thursday, January 22, at the Veterans Administration Hospital in Cincinnati. The Ohio Society of Internal Medicine has that part of the program which starts at 4:20 p. m. and terminates at 5:30 p. m.

The special planning for this part of the program will be the presentation of a panel dealing with the subject matter "Status of the Internist in Medical Care Plans." Moderator of the panel will be Dr. Hamwi. The panel will consist of four members: Dr. William B. Walsh, Associate, American College of Physicians, and chairman of the Legislative Committee of the American Society of Internal Medicine, Washington, D. C.; Dr. John J. Grady, chairman of the Committee on Insurance Plans of the Cleveland Society of Internal Medicine, Cleveland; Mr. Charles H. Coghlan, executive vice-president of the Ohio Medical Indemnity, Inc., Columbus; Dr. Paul I. Robinson, coordinator of medical relations for the Metropolitan Life Insurance Company, representing the Health Insurance Council, New York, New York.

Health Director Reports . . .

Dr. Dwork Tells Health Commissioners Conference About the Major Department Activities and Problems at Recent Session in Columbus

AT the recent 39th Annual Conference of Ohio Health Commissioners in Columbus, Dr. Ralph E. Dwork, Director, Ohio Department of Health, presented a detailed review of various activities and problems of the department. Following is an abstract of Dr. Dwork's talk.

* * *

For the state director this Conference provides a somewhat captive and certainly a most receptive audience. It is an opportunity for him to review the work of the State Department of Health, its problems, its hopes for the future; to comment on the work of local departments and cooperative ventures; to philosophize perhaps and even to dream a bit on the nature of public health and its growth.

Several things have occurred since our last meeting, in 1957, which have had an effect on our operational program both from an administrative and from a management viewpoint.

Although the fourth issue of the Financial Report of Local Health Departments indicates an increase in funds in most local areas, such was not the case in the State Department of Health.

Financial Problem

Late in February of this year, we were requested by the State Department of Finance to reduce our expenditures, insofar as state appropriations were concerned, by approximately $200,000 for the last three months of fiscal 1958. This was not easy.

For the three months of April, May and June we had to reduce planned expenditures within the Department itself by $67,000, and at the two tuberculosis hospitals, by $133,000. This meant, for example, that we did not open 27 of the planned 77 beds in the hospital at Nelsonville. In our hospital on the Ohio State University campus it called for consolidation of wards and eventual closing of 30 beds.

This same type of enforced restriction in expending funds appropriated to us by the Legislature is in effect during the present fiscal year and will continue at least until next June. For fiscal 1959 we have had to decrease the budgets of the two tuberculosis hospitals by $203,000 and the departmental budget by $100,000.

Cuts Made

These cuts, along with a decrease of about $65,000 in our tuberculosis grant-in-aid allocation and smaller reductions in other federal funds, made it necessary to reduce the cash grants of federal monies to qualified local health departments by approximately 20 per cent in fiscal 1959 as compared to fiscal 1958.

Analyzing our most recent publication depicting the financial situation in local health departments, on the other hand, we find that local appropriations for calendar 1958, excluding federal grants, is $12,508,184. This is a gain of almost $900,000 over 1957.

This anomaly of an increase in local funds, at the same time as a decrease is occurring in state funds, is partially explained by the recent mild recession, which we hope is about ended. State income is based largely on such sources as sales, gasoline and liquor taxes which are extremely sensitive to changes in consumer spending, whereas local revenues depend to a large extent on more stable sources such as taxes on real property.

It would be unfair not to point out that if consumer spending should drop again, eventually there would be an effect on local funds which might be reflected next year in smaller appropriations for local health departments. But as we said, there is hope that the recession is ended, that a leveling has occurred, even that an upturn has taken place.

Activities Curtailed

Because of the cuts in our funds, immediate steps had to be taken to cancel all existing vacancies and to fill only critical positions, as subsequent vacancies occurred. This, of course, has reduced our field program to some extent and limited the inauguration of some new programs we had planned.

We did, however, continue our program of allocating funds for special projects to local health departments in those activities particularly related to chronic diseases, rehabilitation and other phases of the aging problem. Last year we allocated about $60,000 for programs of this kind, and this year have increased it to about $90,000. These funds were specially earmarked in our federal gen-

eral health grants. We expect to carry the special project allocation idea even farther in fiscal 1960.

Special Projects

Starting in July of next year, all funds available for field allocation from our federal Heart and Cancer grants will be assigned exclusively for conducting special projects. This, we hope, will be the future pattern, with more and more funds allocated on the basis of approved special projects until such time as all our funds for field distribution will be handled in this manner. At that time, assignment of federal funds to qualified local health departments on a formula basis will cease to exist.

I feel sure that you will agree with me that this approach to use of such funds ultimately will raise the level of health activity in the state, since we will be working on specific planned projects and not on overall generalized programs.

Another anomaly in the financial picture is a drop of two cents in the average per capita appropriation in local health districts, despite the total increase of nearly $900,000 which I previously mentioned. The average for this year is $1.35. The answer here is—increasing population. In full time departments, the per capita average for 1958 is $1.44; in part time departments, $.87.

In this connection, it is worth noting that nationally there are similar problems in trying to maintain a pace of growth in public health comparable to the growth in population. In a recent bulletin of the National Advisory Committee on Local Health Departments, it was noted that the ratio of health personnel to population was less favorable in 1957 than in 1950. . . .

Status of Local Departments

This is a good point to review the local health department status in Ohio. As of January 1, 1958, there were 132 local health units in the state. Sixty-nine of these are in the full time, qualified class, serving a total of 162 local health districts. Sixty-three part time, unqualified units serve another 72 local health districts.

This represents an elimination of four part time, unqualified units since last year, and the addition of seven qualified local health districts. It is worthy of note that there was a reduction of health units even though three new health districts were added during the year. Of the seven districts gaining qualified status, six were achieving it for the first time. One was regaining its former qualified status.

No area lost qualified status during the year. Approximately 84 per cent of the total population of Ohio now is served by full time qualified health departments.

Public Health levies were attempted by seven general health districts last fall. They were passed in only four, and three of those, were renewals.

Public Relations

In the past, the successful counties, so far as levies are concerned, have been those which have enlisted community participation, in the early planning of an educational program and campaign for the levy, usually with a local community group sponsoring the campaign.

Our Health Education Division has helped in the organization of such endeavors in a number of areas. The success stories have come definitely from those counties which planned early, secured key leadership from many segments of the population and worked hard on materials and methods of getting information to the general public.

The conception, development and maintenance of good public health programs call for a continually alerted, informed and interested citizenry. Where this exists, organization for support of tax levies, or for other types of support, is easier.

In this connection, let me make reference to use of the Health Services Report, the new document for reporting health department and other community health services, now in its third year.

We feel (and a number of you have said that you also feel) that the Health Services Report, when selectively applied, can be one of the best tools available to assist in the development of better community health services through joint agency program development and community planning. The full potential of this document is only beginning to be explored.

Turning now to the disease entities which have been of principal concern to us, we find that for a number of reasons tuberculosis has been demanding much of our time. Despite steady gains against it, it still is far from being under control. And actually, as the prevalence of tuberculosis continues to decline slowly, it becomes evident that we need more productive methods of case finding. X-raying on a mass basis is an expensive, low-yielding operation today without careful preselection of population groups to be x-rayed.

Use of the tuberculin test is getting a marked increase in interest these days. On a pilot basis we are now exploring use of the tuberculin test in tuberculosis control in two counties. Other tests are tentatively planned for the coming year. We are seeking the answers to many questions about both the use and limitations of the tuberculin testing method.

T. B. Bed Occupancy Problem

Perhaps the most important single development of major concern in tuberculosis control,

since our last Health Commissioners' Conference, has been the bed occupancy problem. Occupancy averaged 70 per cent over the state as a whole as of July, 1957; it ranged from 43 to 92 per cent. This is a remarkable change from just a very few years ago when waiting lists were the universal rule.

While the relative importance of all the factors contributing to this problem are not completely understood, it is our best judgment that the most important single factor is the decreased length of hospital stay. This has resulted from the use of antimicrobial drugs and pulmonary surgery in tuberculosis therapy.

Decreased occupancy has quickly been reflected in increased per diem cost of hospital care. This and other considerations have caused boards of trustees and county commissioners to look critically at local situations and to consider partially or completely closing some sanitoria; or to consider converting either partially or completely to the care of other diseases.

State-Wide Study

Treating the problem on an individual local basis had seemed sufficient until recently. Toward the end of last year, it became apparent, however, that to avoid a disproportionate distribution of beds, the problem needed a state-wide view and long-range plan of attack. To this end, a meeting with medical directors of the sanitoria along with executive secretaries of Tuberculosis and Health Associations in the ownership counties was held in January of this year. A committee with representatives of the interested agencies was appointed to explore the problem in more detail. Later this month at another meeting of the original group, this committee is to present its preliminary findings.

There is a point in this which should be of special interest and concern to local health commissioners. More patients are being discharged in a rehabilitable state. They will require outpatient or clinic follow-up services for a longer period than formerly. The public health aspects of the care of tuberculosis, therefore, may be expected to put more than less demands on local health departments. In this aspect of the problem, we are in need of and will welcome consideration and advice from local health commissioners. This problem promises to be one of major administrative and medical importance for some time to come.

Status of State T. B. Hospitals

With respect to our own two tuberculosis hospitals on the campus of Ohio State University and at Nelsonville, I already have mentioned the effect of economies in limiting the number of available beds. I might report that the new recalcitrant unit in the Columbus facility, opened November 4, 1957, has admitted 32 patients to date. Of this number, five have been discharged. After periods of observation and indoctrination, most of these patients have been treated on open wards and have evidenced fairly good cooperation.

Along with the new problems in tuberculosis control, we still have the continuing problem of frequent ill-advised use of home therapy in active and usually infectious, illness. This procedure is dangerous to both patient and community, and all too often it has been condoned by local health departments.

Asian Flu

During the past year, our most dramatic experience was in dealing with the epidemic of Asian strain influenza, which gave us an unprecedented opportunity to work out with local health areas, a state-wide surveillance program involving in addition to morbidity and mortality reporting, the prompt communication of school and industrial absenteeism. Cooperation from local areas was excellent. Our ability to keep abreast of the situation on a state-wide basis exceeded our expectations.

The influenza outbreak in Ohio began during the early part of September and reached a peak in the latter part of October and early November. Cases continued to occur in early 1958, and an increase in incidence in March has been considered by some to have been a relatively minor second wave. No evidence has come to light which suggests that any substantial change in virulence of the organism occurred during the course of the epidemic. While morbidity was relatively high, and frequently the attack was over 50 per cent in given school populations, mortality was relatively low and remained so during the course of the outbreak.

In all, approximately 9,000 cases were reported, and 607 deaths were thought to be directly or indirectly the result of influenzal infection. The morbidity figure, of course, represents only a small fraction of total morbidity. The mortality figure likewise may be misleading. That the influenza virus was directly responsible for some deaths, however, has been confirmed by isolation of the Asian strain virus in the Ohio Department of Health Laboratory from postmortem specimens.

The influenza epidemic brought an onslaught of more than 2,000 specimens to the Laboratory. It gave a concrete example of what an epidemic can do to normal laboratory operation.

Planning for most advantageous use of vaccine, proceeded smoothly with admirable cooperation from all agencies involved. Due to the early

onset of the epidemic it is certain that the vaccine played little or no control because of the small amount of the material available at the time. Vaccine effectiveness at a 50 to 80 per cent protection rate has been confirmed by control studies of the U. S. Public Health Service.

There is some possibility of an influenza outbreak during this coming winter. It is likely that the Ohio Department of Health will conduct surveillance programs patterned after the system used last year.

Staphylococcal Disease

Hospital-acquired staphylococcal disease has continued to be a major problem in infectious disease since our last meeting. Considerable progress has been made in investigation of the epidemiology of the disease, and its significance as a public health problem of national scope has been well delineated.

Precise methods of control within the hospital still are unknown and a vast amount of confusion exists in this area. One method of attack receiving almost universal acceptance, is establishment of intra-hospital infection committees. Such committees—comprised of members of the various medical services, nursing service, laboratory and administrative staff—have become a requisite for accreditation of general hospitals. Establishment by these committees of methods of communication within the hospital and systematic surveillance of infections is expected to be of value in early detection and subsequent control.

The importance of hospital-acquired infections as a hospital problem is now well recognized. Less well appreciated is the hazard that infected individuals present to the community after discharge. Organized public health has a responsibility in this area of threatened serious increase in community-acquired staphylococcal disease. The amount of time and effort that may be required, especially on the part of nursing staffs and laboratories, is tremendous. Obviously adequate means of communication between different hospitals, and between hospitals and health departments are essential. No blueprints of successful methods are available for this, and it falls on each of you to use local ingenuity in working out suitable communication procedures within each local jurisdiction. It is our feeling that the work of many local departments and our own department in this field during the past year has gone a long way toward improving hospital and health department relationships and should help to pave the way for continued productive work.

Polio

Through the first week in September 1958, 102 cases of poliomyelitis have been reported. This may be compared to the 163 cases which were reported through the same period in 1957 and to a mean number of 774 cases reported for the same period during the previous five years. Forty-two paralytic cases have been reported, 5 of which have been fully vaccinated. Four deaths due to poliomyelitis have been reported, all in unvaccinated individuals.

Interpretation of the steady decline in the incidence of poliomyelitis and its relationship to the widespread use of vaccine continues to be difficult, but the conclusion that vaccine has made a real impact on the disease is becoming more and more inescapable. The work of the local health departments in initiating and maintaining vaccination programs, often in the face of financial difficulties and sometimes frank opposition, is worthy and commendable. We regret that in the past year we have not been able to help materially with these programs. There still remains a substantial portion of the population without polio immunization and it is our intention to ask the next Legislature, as we did the last, for funds to assist local health departments in this valuable program.

At the last Conference, I mentioned to you the tremendous effort that was being made by several departments, especially in the southeast area, to combat a serious problem of endemic rabies among dog and wildlife population. During the past year these efforts have borne fruit and we have witnessed a dramatic decline in the incidence of canine rabies in several of the counties involved. We feel that it is fair to interpret the reduction as a result of control programs.

Laboratory Problems

Our Laboratory examined nearly 1,500 animal heads last year, in 251 of which evidence of rabies was detected. Studies on the extent and significance of rabies in bats is being continued. Evidence of rabies was found in a group of 35 bats from the Northeast section of the state. Recently the Laboratory received 45 bats from a southern section, but results on these are not yet available.

While we are talking about the Laboratory let me indicate that the Department is cooperating in national polio-surveillance studies, with the Laboratory providing direct support, as heretofore. Laboratory findings should provide important data on the value of Salk vaccine. Last year, as in the previous year, a wide variety of Coxsackie and ECHO viruses were isolated from cases of aseptic meningitis. The most prevalent of these in 1957 was ECHO 9. Again this year we have encountered a variety of viruses in aseptic meningitis.

Use of the Laboratory as an aid in diagnosis of viral diseases may be increased by the addition of

new techniques. The Communicable Disease Center is helping by furnishing a variety of antigens and antisera not previously available. The poliomyelitis complement fixation test is one new procedure now available for use on paired sera. It is anticipated that practical serological tests for measles and Coxsackie infections may become available. The Laboratory is planning to explore uses of fluorescent antibody techniques as a means of rapid detection not only of viruses, but also of bacteria. Special studies involving newer respiratory disease viruses and virus-tumor relationships are in progress. The tissue culture laboratory has explored the use of five cell lines in the past year.

Leptospiral agglutination tests continue to detect cases of this infection in Ohio. The Laboratory Division recently added eight new strains as antigens in the testing program, and surveys of infection in the wild animal population were made in conjunction with the Veterinary Unit of the Division of Communicable Diseases.

Histoplasmosis and trichinosis are often important disease entities in this state. Our Laboratory has run over 500 blood specimens for histoplasmosis and 150 for trichinosis. Among unusual outbreaks discovered was one of histoplasmosis in eight quarry workers, and a hospital outbreak of trichinosis involving 70 persons.

Diabetes Screening

A new activity was added in the chemistry section of Laboratory, the examination of blood specimens for sugar in connection with diabetes screening.

At the last Health Commissioners' Conference, a detailed report on the diabetic screening project in Union County was presented. Since then very similar programs have been conducted in Jackson, Huron, Darke and Brown Counties, with about 9,000 persons tested. Results from all the tests are not yet available, but from 4,700 persons tested, 68 previously unknown diabetics were detected and referred to their private physicians. We plan to continue this work in the coming year, surveys having been arranged already for Greene and Preble Counties and others to be scheduled later. It is our firm belief that these programs represent sound public health endeavor. We commend those areas willing and able to participate in the pioneering of detection of non-infectious chronic disease. This certainly fits into the principal purpose of public health—to prevent occurrence of disease and disability.

Rheumatic Fever Program

There is continued high interest in the rheumatic fever prophylaxis program. Since the initiation of this program in April, 1957, a total of 3,352 persons have been enrolled in the program, with 82 of the 88 counties participating. From what we can determine, the program has been well accepted by the medical profession and greatly appreciated by participating families. The number of patients brought into the program is greater than we originally expected, and the cost too has been greater. Because of the potential value in the prevention of repeated attacks of rheumatic fever, we hope sincerely that this program will be continued. We hope no change will be necessary for the remainder of this fiscal year. I anticipate that it may be necessary to seek partial local support in this program by July, 1959. If this should be true, a thorough discussion of the problem and possible methods of local financing would be planned as far in advance as possible.

Mention might be made here of a new procedure in cardiac detection through screening of tuberculosis x-rays. Having the films re-read by a cardiac reader did not appear to be greatly productive in terms of detection of cases of heart disease which could be benefited by physician referral. This program, therefore, has been modified. In place of the re-reading, our tuberculosis readers now look more intently and specifically at the heart shadow and have increased their index of suspicions of abnormality. It is hoped that this compromise method will obliterate some of the problems of gross over-reading of possible defects, but at the same time provide useful information concerning probable or definite heart disease.

Hearing and Vision Programs

Something new also has been inaugurated in our hearing program, specifically, a team approach to differential diagnosis. In many previous otological diagnostic clinics, we had felt a need for a more comprehensive type of screening. There were children in whom we suspected other difficulties in addition to hearing defect, possibly mental or emotional block. Routing children to special facilities for additional examination at some distance was difficult. We decided to try an evaluation on a demonstration basis at a central location in the area being served. In this case, it was southeastern Ohio, and a Differential Diagnostic Clinic was set up at Nelsonville. This clinic, using a team approach, is staffed with specialists affiliated with or acceptable to Children's Hospital in Columbus (where the children otherwise would have been routed in this case.) In addition to the regular members of our Hearing and Vision Unit, the Clinic is staffed by an otologist, pediatrician, clinical audiologist, clinical speech pathologist and clinical psychologist. Only six to eight

children are seen in a clinic day and each case is discussed in detail by the entire clinic staff. Comprehensive recommendations are made and forwarded to the referring physicians or agencies. Already a few children have been found who previously had been declared uneducable and were being kept at home but who would fulfill admission requirements of the State School for the Deaf or, in a few cases, the State School. The latter group, with I. Q.'s from 60 to 90 on first testing, stand a good chance for rehabilitation. In addition to filling a definite need, the Clinic is serving as a training facility for advanced students of Ohio University.

In this connection I should not fail to mention our new Hearing Cruiser. It was, as most of you know, specially built after extensive consultation. The Cruiser can be taken to any location where there is a source of electrical power and can be set up for testing within a short time. The arrangement of equipment will permit individual or group audiometer tests as well as more intricate methods of testing. It is attracting considerable national attention and we are proud that we have pioneered in its wider use.

New policies for vision conservation programs in schools have been drafted by an advisory board to the Department, in which somewhat greater emphasis is placed on early testing and case finding, preferably during the pre-school period. We hope that printed copies of these policies will be available for distribution during this meeting; or shortly thereafter.

Retarded Children

I think it would be worth a moment to talk about the Hamilton County Diagnostic Clinic for the mentally retarded. Four different agencies are involved in the project: the Ohio Department of Health, the Department of Mental Hygiene and Correction, Children's Hospital of Cincinnati, and the Hamilton County Diagnostic Clinic for the Mentally Retarded. The Clinic is staffed by a board pediatrician, a clinical psychologist, a psychiatric social worker, a pediatric nurse, and other highly trained professional persons on a full or part time basis. The Clinic will emphasize the need for early detection and the evaluation of the degree of retardation. It is our hope that it will be increasingly used as a training center.

Nurses Training

I should like to call your attention again to the extension courses being offered presently employed public health nurses at Ohio State University, Western Reserve, and University of Cincinnati. These courses call for only a half-day a week for a three to four month period and give college credit toward a B. S. degree. Approximately 200 nurses participated in these courses during the past year, and I want to congratulate those of you who made it possible.

It has been brought to my attention that there seems to be an increasing trend throughout the state toward the direct employment of nurses by voluntary health agencies for service in homes. This would only be happening because the public is wanting such service, and the voluntary agencies, being very sensitive to public wants, have been quick to step in. This is *your* problem on the local scene. Are you considering it? Is your own department failing to meet demands for home nursing services?

Are voluntary agencies in your area thinking of establishing separate nursing services? The choice is to a large extent in your hands, according to the action you take and your relationships in the community and with the voluntary agencies. By taking no action at all, you may wind up with a whole series of separate nursing services over which you have no control. You might be able to work out a combined service, partially supported by voluntary funds but operating under single public health direction. Or you may be able to satisfy the needs with expanded home nursing services from your department. Consideration of fees for some types of home service may come into this. It is my information that county welfare departments, for example, would be just as willing to pay health department nurses for home service as any other nurses. You might consider all these facts in determining your own course of action.

Nutrition Service

Also I should like to call your attention to the new "Ohio Diet Manual" produced by our Nutrition Service in cooperation with the Ohio Dietetic Association and other interested professional groups. It is a simplified manual suitable for use by cooks and food service supervisors in nursing homes and small hospitals which either cannot find or cannot afford professional dietitians. Physicians throughout the state repeatedly have mentioned the difficulty in obtaining suitable dietary modifications for patients in these smaller institutions. This new manual also will be a big help to public health nurses. And frankly, a number of health commissioners, themselves, have been using this manual to bring themselves up to date on diet therapy. The simplest way to get a copy is to get in touch with your district nutrition consultant.

The shortened period of hospital stay for tuber-

culosis patients brings another point of focus in need for nutrition education. Many of these patients have come to the hospital with established eating habits not conducive to good nutrition. They need guidance during their stay in the hospital and further help after returning home. A nutrition education program now is being conducted in 17 tuberculosis sanitoria. In nearly all of these, patients are given the opportunity and encouraged to attend the classes. Public health nurses in areas being served by these sanitoria are being oriented to the content of these classes and are developing plans for follow-up with patients' families.

The Fourth Ohio Conference on Human Nutrition, of which our Department was the principal sponsor, was highly successful this year, aimed particularly at school teachers and administrators, and had an attendance of more than 600. The next conference, tentatively scheduled for 1960, probably will be designed to meet the special needs of physicians and nurses on the staffs of local health departments. We shall welcome any suggestions you may have in this connection.

Industrial Hygiene

Turning to the field of industrial hygiene, it gives me pleasure to be able to state that a very effective attack has been made on the narrow concept that the industrial worker's health is for some reason unrelated to the total community. This attack was spearheaded by a series of Industrial Health Institutes arranged to indoctrinate the 1500 industrial nurses of our state in the principle that industrial health is an integral part of community health. It was apparent that many of these nurses not only welcomed but had been waiting for an invitation to become an important segment of the community health effort.

The philosophy that industry and the community are a whole and not separate entities is nowhere better illustrated than in the field of air pollution. For too long we have thought of air pollution as a mere technical problem. True, there are many technical problems to be solved, but none of these is quite so intriguing and profound as uniting the community and industry to achieve a single goal. Passage of Section 3701.041 of the Revised Code, effective September 7, 1957, relative to conducting atmosphere pollution research by the Department of Health and assisting sub-divisions in the abatement of pollution, makes clear that Ohio communities do want air pollution control. We believe that the abatement of air pollution can be accelerated by the united efforts of official health agencies, community associations and management groups. It is hoped that the Department will be able to help initiate a number of such cooperative efforts in the year to come.

Radiation Problems

Prevention of unnecessary ironizing radiation is another area in which the Division of Industrial Hygiene now is absorbed. This year, the State Public Health Council adopted a regulation banning the use of x-ray shoe-fitting machines except by physicians and chiropodists. This action is but an infinitesimal step in the total radiation problem in the state, however.

Do you know that Ohio now has three nuclear reactors operating or under construction, and that three more have been licensed for the state? As with air pollution there are difficult technical problems related to the safe operation of reactors. Yet these problems are presently surrounded by an uncertainty of the responsibilities to be assumed variously by the Atomic Energy Commission, U. S. Public Health Service, the Office of the Coordinator of Atomic Development Activities in Ohio, State Health Department and local authorities. We hope that in the year to come a clearer delineation of these responsibilities will be forthcoming.

Water Pollution Control

It probably has been impossible for you not to observe at least some of the progress being made in the state in the field of water pollution control. This is apparent now in virtually every part of the state in the rising construction of new municipal and industrial waste treatment facilities. As a matter of fact, the first five years of the new Water Pollution Control Board program has seen an actual doubling of the total capacity of municipal sewage treatment from approximately a half billion gallons a day in 1952 to more than a billion gallons a day now.

Three more cities and 14 new villages which lacked sewage treatment have placed treatment plants under construction since our last Conference. Another 10 municipalities, including two more cities, are to let contracts during the fall. We are very certain that these projects will be placed under construction quickly, because federal grants approved by our Department are contingent upon early construction.

Important waterworks improvements also were undertaken by 23 cities and 39 villages during the past year. Total valuation in plans reviewed by our Engineering Division for the year was more than $110,000,000. This included municipal and county water supply and purification facilities,

sewerage and sewage treatment facilities, and industrial waste treatment.

Food Service Licensing

It is our feeling that Ohio's food service program is maintaining a high level of performance and satisfactory progress in the interest of safer food for public consumption. Food service programs of all city and county health departments were reviewed last year by the State Department. Measured against established criteria, 146 local health agencies were judged to be conducting satisfactory programs. Of 22 local programs deemed to be inadequate, only six were considered in serious difficulty.

Hospital Facilities

In the field of hospital facilities, we received an allocation of $4,493,652 for the fiscal year recently ended. To this was added $198,113 transferred to Ohio from Kentucky for assignment to the Goodwill Industries Rehabilitation Center project in Cincinnati. When completed this center will serve a number of border communities along the Ohio River in both states. Nineteen Hill-Burton projects have been approved in the approximate period since our last meeting. Twenty-one other projects are in the active planning stage and 10 in preliminary planning.

On the subject of buildings, . . . we are again asking the Legislature in its next session to consider funds for a separate State Department of Health Building. Many other state health departments do have their own buildings. I am sure that we could do a much better job if our divisions and units were together again.

We have many important going programs in which we must do everything we can to generate new incentive and drive; there are also many new programs just getting started, which are vitally needed, and for which we must contribute all the technical knowledge and experience that we have collectively, plus that added spark of ingenuity which often is the breath of life in gaining public support.

Arthritis To Be Postgraduate Subject at Northwestern

A postgraduate course in arthritis and related conditions will be given full-time on February 19, 20 and 21 at Thorne Hall, Northwestern University, Lake Shore Drive at Superior Street, Chicago. Tuition is $50. The faculty will be from all Chicago medical schools and will include six nationally known guest lecturers. Details may be obtained from Frank R. Schmid, M. D., 303 East Chicago Ave., Chicago 11, Ill., Secretary.

When To, When Not To, Perform Chest Fluoroscopies

The medical director of a large life insurance company recently asked the American College of Radiology about routine fluoroscopic examinations of the company's home office employees, as part of an annual physical examination. Crux of the medical director's query was whether this was a wise practice. The inquiry was referred to Dr. Richard H. Chamberlain, Philadelphia, Pa., chairman of the ACR Commission on Units, Standards and Protection. Excerpts from Dr. Chamberlain's personal opinion expressed to the insurance company medical director are presented below.

* * *

"I quite agree with you that there are proper indications for fluoroscopic examination of the heart and lungs in certain situations and that this should not be a cause of concern either to individuals or to their physicians, providing the reasons for such studies are adequate and the technique and apparatus used for it is of the modern type and with due attention to reduction of radiation exposure.

"With respect to the annual examinations of your employees, I think that one must exercise a different order of indication and that it is unlikely that a fluoroscopic examination is either suitable for or required as part of survey procedures for tuberculosis. In almost any instance, even several x-ray films would give tremendously less exposure and would actually give more detailed information. . . . I would like to call your attention particularly to [the College *Manual* on Protection] the practical section on chest fluoroscopy and also to the first section on "Other Procedures," which discusses the chest survey examinations. By comparing the values of exposure shown here, I think that it is obvious to you that chest fluoroscopy should be limited to situations with particular indications for the dynamics that are observable therewith.

"We are interested only in a fair and proper control of radiation exposure, veering neither too far towards the overly cautious side nor denying people the proper and excellent benefits derived from modern radiology. I am sure that this is also your attitude and anything that we can do together to forward this approach will be a mutually happy arrangement."—*American College of Radiology Newsletter.*

The average person today sees his doctor about five times a year, Health Information Foundation reports. In the aggregate, Americans use between 800 and 850 million physician visits a year.

WARNING TO ALL MEMBERS!

Your Memberships in the Ohio State Medical Association and American Medical Association, Including Subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA,* Will expire on December 31. Here's How To Renew Them:

It's time for all members to pay 1959 membership dues—local, state and national—unless in an exempt classification.

Mail your check immediately for dues to the SECRETARY-TREASURER of YOUR COUNTY MEDICAL SOCIETY.

OSMA dues are $25.00. AMA membership dues are $25.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer.

Many members probably will want to send one check to cover local, state and national dues. Make Check Payable To Your County Medical Society. If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words, "For 1959 AMA dues."

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Remember: As a part of the privileges and services offered to all members of the OSMA and the AMA, you will receive a year's subscription, without extra cost, to *The Ohio State Medical Journal* and *The Journal of the AMA* — or some other AMA publication of your own choosing.

Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1959, to keep them current.

Members who were exempt from paying OSMA or AMA dues, or both, in 1958 will be carried over automatically on the 1959 membership roster of both organizations unless their status has changed.

Tax Roundup for Physicians . . .

Here Are Pointers for Doctors and Summaries of State and Federal Tax Laws Under which Most Physicians Make Periodic Returns and Payments

DURING the early part of 1959 physicians will again face the task of filing returns and making payments under several categories of Federal, State and local tax laws. This article is presented for the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted.

(1) Federal Income Tax Law, including payroll withholding on employees' salaries.

(2) Federal Social Security Tax including Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicains are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Taxpayers will pay 1958 Federal Income Taxes under provisions of the Revenue Code of 1954. Computation of this year's tax will be similar to that of the last three years since there have been no changes in the law.

Forms and Payments

Every person under 65 years old whose gross income for the year was $600 or more, and every person 65 years old or older whose gross income was $1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1959.

There are three types of returns, Form 1040A, Short-Form 1040 and Long-Form 1040.

Form 1040A may be used if the income was less than $10,000 and consisted entirely of wages reported on Withholding Statements, or such wages and not more than $200 total of other wages, interest and dividends (excluding $50 of dividends). When this form is used, if the income was under $5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was $5,000 or more, the taxpayer must compute his own tax.

Short-Form 1040 is used if the income is less than $10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Long-Form 1040 must be used if the income was $10,000 or more, or if the taxpayer wishes to claim nonbusiness deductions that amount to more than 10 per cent of income.

Income-Splitting

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

Declaration of Estimated Tax

The provisions for filing declarations of estimated income taxes are principally for those persons, a substantial part of whose income is not subject to withholdings.

When filing a final return for 1958, on or

before April 15, 1959, most physicians will be required to file an estimate of 1959 income.

If income from items other than wages is $100 or less, declarations are required if the gross income from wages subject to withholdings can reasonably be expected to exceed $5,000 in the case of a single person; or $10,000 in the case of a married couple, head of a household or surviving spouse.

If income other than wages subject to withholdings can reasonably be expected to exceed $100 (excluding $50 from dividends), a declaration is required if total income including wages subject to withholdings can reasonably be expected to exceed $600 multiplied by the number of exemptions that could be claimed on the taxpayer's return, plus $400.

Times to file declarations of estimated tax by individuals is April 15 (or at time final return is made), June 15, September 15 and January 15. The date for filing an income tax return in lieu of a final declaration of estimated tax is January 31. Thus, if an income tax return is not filed before February 1, the last day for filing declaration or an amended declaration is January 15.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed. For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

Physicians in Private Practice

To summarize, most physicians in private practice must comply with the following procedures:

1. On or before January 15, 1959, make a fourth quarter return on declaration of estimated income for 1958.
2. On or before April 15, file a complete income tax return for 1958.
3. Pay the difference, if any, between the income tax paid quarterly and the amount of tax liability shown on the final return. If he has overpaid, the excess will be refunded or credited against future payments.
4. On or before April 15, file a declaration of estimated tax liability for 1959, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for payment are June 15, September 15 (and January 15, 1960).

Adjusted Gross Income

Individuals who are employed and receive a salary have little difficulty in arriving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the amount of his cash receipts—if he reports income on the basis of cash received and dibursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

Deductible Business Expenses

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **cannot** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office, and the proportion of operating expenses chargeable to the office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, bus fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is determined by dividing the cost price of the machine, less salvage value, by the number of years of its usefulness. Salvage value is the estimated amount that will be realized upon sale or disposition of the automobile at the end of its useful life—the useful life varying according to the policy of the taxpayer.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

The physician should seek the advice of a tax expert as to whether or not application of the

"declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

Refresher Courses—The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Sec. 1.162-5 of the Internal Revenue Service regulations).

The regulation provides that expenditures for education are deductible if they are for "refresher" or similar types of courses taken to maintain the skills directly and immediately required by the physician in his employment or practice. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit.

Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses—When a physician travels away from home primarily to obtain "refresher" education or to attend a medical convention for professional purposes, his expenditures for travel, meals, lodging, etc., are deductible. However, expenses for personal activities such as sight-seeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone. For example, if he and his wife have a double room, he may deduct the amount that he would have paid for a single room.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Depreciation—Depreciation may be claimed on instruments, laboratory equipment, office furniture, books, etc., of more or less permanent value, the rate of depreciation depending on the estimated useful life of the article. The "declining-balance" method of depreciation permits the taxpayer to charge off a larger proportion of the cost of equipment during its early life, under certain conditions.

If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Uniforms—The Internal Revenue Service permits deduction of the cost of medical uniforms (garments, etc., necessary in practice but not suitable for street wear) as business expense.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purpose) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer



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A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula. . . . Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus —"Within four days appetite became excellent, took full diet. . . . More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Degree Burn —". . . soon began eating all that was offered. . . . Began to show signs of hope for recovery. . . . Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg. and ampuls of 25 mg. (1 cc.).

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upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fees and expenses paid for "securing the right to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician must pay, including narcotics registration and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

The United States Tax Court in a case decided in June, 1957, held that premiums paid by a doctor for disability insurance **are non-deductible** personal expenses, even where the policy is called a "Professional Income Policy." In the case before the court, there were no provisions in the insurance policies specifying that payments thereunder during disability were to defray or reimburse the holder for business or overhead expenses. Specific provision must be set forth in any policies of this type that the amounts will be for business or overhead expense in order to make the premiums deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

Ohio and Federal Gasoline Taxes—There is a five cents per gallon Ohio tax on gasoline, and a three cents per gallon Federal tax. These amounts are deductible. However, if a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio 5 cents tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible. The cost of contesting tax liabilities is deductible.

Entertainment Expenses

Following are excerpts from a communication sent to a medical society in Mississippi by a District Director of Internal Revenue which the Law Department of the AMA says was one of the best explanations regarding deduction of physician's entertainment expenses it has seen:

1. A physician may deduct on his federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service, by appropriate evidence, that such expenses are ordinary and necessary business expenses and clearly related to the production of business income.

2. The amount of the deduction must be proved

and its reasonableness determined. Once the amount is established, the deduction may be claimed when the doctor is able to show that the entertainment had a direct relationship to the conduct of his practice and can show the business benefit reasonably to be expected from the expenditure. The general statement that he hoped or expected to get referrals or patients as a result of the entertainments is not enough. If personal reasons predominate, the expenditure may not be deducted, even though there is some possibility of a business benefit. Except in the case of industrial physicians, entertainment of individuals who are not doctors will not ordinarily qualify because the possibility of benefits to be expected is so remote as to be negligible. In instances of the entertainment of patients, the same general rules apply as in the entertainment of other doctors, and the clear relationship of the expenditure to reasonably expected income must be shown. The same rules also apply to civic and other club dues.

Criteria to be used in establishing the deductibility of entertainment expenses include, but are not limited to, the following:

a. Specific purpose of entertainment. b. Nature of the practice of the doctor incurring the expenditure. c. Period of time the doctor has been in practice and the number of patients he already has. d. Percentage of his patients received as referrals. e. Names of individuals entertained and reason why additional income could reasonably be expected from each. f. Whether or not referrals were actually received from the doctors entertained and any indication of the effect of the entertainment on these referrals. g. Number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive. h. Whether or not other doctors in the same type practice in the locality have entertainment expenses.

Exemptions and Allowances

An exemption of $600 may be claimed by the taxpayer for himself. He may also claim an exemption of $600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of $600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

Contributions, Gifts, etc.—The individual taxpayer may deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which are carrying on propaganda or otherwise attempting to influence legislation.

Medical and Dental Expenses—The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed $2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) $5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) $5,000 if the taxpayer is married but files a separate return; or (c) $10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross income. In effect, the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

Medical expenses paid by an estate within one

(Continued on Page 1636)



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GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.
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ORAL SUSPENSION
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125 mg. per tsp. (5 cc.)
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NEW! PEDIATRIC DROPS
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COSA-TETRASTATIN*

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

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For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurances)."

In regard to payment of premiums on accident and health insurance, the Internal Revenue Service has ruled that premiums may be deducted for insurance that provides for indemnity for the cost of medical care and specific injury, but may not be deducted for insurance which indemnifies the holder solely for the loss of earnings.

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this will furnish the Internal Revenue Service with data which can be used in checking returns filed by physicians and dentists —another reason why they should keep accurate records and compile their returns carefully.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

Optional Standard Deduction

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000; or $500 in the case of a married person filing a separate return.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return. The tax liability falls upon the individual partners. Partnerships may be simple agreements by which two or more physicians share expenses and prorate income. On the other hand, they may be elaborate entities. Since there are many special regulations pertaining to partnerships, partners would do well to seek expert advice.

Retirement Income

Retirement income, including pensions, annuities, interest, rents, dividends, etc., are subject to special treatment under the income tax laws.

District Offices and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, 110 W. Long St., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Drake, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to **one or more** employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of

exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

Deposit of Withholdings

An employer who withholds as much as $100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

Report of Funds Paid

As in previous years, payments in excess of $600 made during the year for interest, rents, or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

A person 65 years old or older who is receiving Social Security benefits may now earn up to $1,200 a year without losing his benefit. For any excess earnings over $1,200 he may lose one month's benefits for each $80 or fraction thereof. A person 72 or older may earn any amount and continue to draw benefits.

Favored Tax Status of Associated Members Has Limitations

Under current rules, the Internal Revenue Service, is not denying to unincorporated associations of doctors favored tax status in regard to pension plans for members. The effect is that members of such associations enjoy approximately the same annuity advantages they would under the Jenkins-Keogh and similar bills now pending in Congress.

Those planning to take advantage of this favored tax status must be careful not to put themselves in jeopardy under the Ohio law prohibiting the corporate practice of medicine.

Not covered for social security purposes are services performed by an individual in the employ of his son, daughter, or spouse, and services performed by a child under 21 in the employ of his father or mother.

Under provisions for coverage of self-employed workers, physicians are specifically excluded.

Domestic workers in private homes who receive wages of at least $50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns $50 or more in a quarter (approximately $3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns $150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

Old Age and Survivors' Insurance Tax

The Old Age and Survivors' Insurance Tax is payable by every employer who employs one or more persons in his office or home.

There is an increase in the amount paid under OASI, brought about by the Social Security Amendments of 1958. Through December 31, 1958, the employer continues to deduct 2¼ per cent of the employee's wages and contribute a like amount himself. Through the current year, the amount is deducted and paid on the first $4,200 of annual salary.

Beginning January 1, 1959, the employer deducts 2½ per cent of the employee's wages and contributes another 2½ per cent himself.

Deductions and employer's payments beginning the first of the new year are made on the first $4,800 of annual salary.

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed on or before April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. The employer who reports his office workers on Form 941 may add his domestic workers to this same form.

Farm workers must be reported on Form 943.

Unemployment Tax

Physicians or other employers who have **three or more** employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have **four or more** are liable also for the Federal Unemployment Insurance Tax.

Ohio Unemployment Compensation Tax

In general, employment of **three or more persons** in any one day including part-time workers renders the employer liable for this tax. A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first $3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have had **four or more persons** on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to $3,000 and is paid exclusively by the employer—the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing **three or more** employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of **less than three** employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 29 annually. One-half of the amount of

83% MAJOR (Grade I and II) IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with PLAQUENIL® or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

Write for Booklet.

[illegible] of chloroquine) and Plaquenil (hydroxychloroquine), trademarks reg. U.S. Pat. Off.

[illegible]
New York 18, N. Y.

the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 5 per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law to list all his taxable property, except inventory, as of the date he engaged in practice. In listing inventory he should list the probable average value (at any one time) intended to be used between the time he engages in practice and the end of the year. The valuation of all taxable property including average inventory to be returned for taxation is determined by multiplying the value by the number of months the taxpayer has been in practice and dividing by 12.

Forms 937 and 902, obtained from the Ohio Department of Taxation, must be filed with the Personal Property Tax return to obtain a lesser value than 30 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar, and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually.

As defined in Section 5701.07 R. C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

Some physicians misunderstand the provision requiring the listing of accounts receivable for taxation. Some think that physicians are the only ones who have to do so and that the law is discriminatory. That is not true.

Every person who possesses intangible assets, *such as accounts receivable,* or any business or professional man who does buisness on credit basis and keeps books, must return his accounts receivable for taxation.

Such person must keep in mind that he can estimate depreciation on his accounts receivable and that he can use *accounts payable* as an offset against accounts receivable, paying the tax on the difference.

Obviously, the percentage discount used by a physician in depreciating the value of his accounts receivable will depend to a large extent on the doctor's collection experience and on the economic status of the majority of his patients. In other words the physician who has difficulty in collecting bills or whose practice serves a large number of persons in the low-income brackets or who are poor credit risks, should use a higher depreciation formula than the physician who does not have these factors to contend with.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes

ANNOUNCING

a new order of magnitude in corticosteroid therapy!

The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy



Decadron*

DEXAMETHASONE

to treat more patients more effectively

MSD MERCK SHARP & DOHME

a new order of magnitude

In Anti-Inflammatory Potency

DECADRON "possesses greater anti-inflammatory potency per milligram than any steroid yet produced,"[1] and is "the most potent steroid thus far synthesized."[2] Milligram for milligram, it is, on the average, 5 times more potent than 6-methylprednisolone or triamcinolone; 7 times more potent than prednisone; 28 times more potent than hydrocortisone; and 35 times more potent than cortisone.

In Dosage Reduction

Thanks to this unprecedented potency, DECADRON is "highly effective in suppressing the manifestations of rheumatoid arthritis when administered in remarkably small daily milligram doses."[3] In a number of cases, doses as low as 0.5-0.8 mg. proved sufficient for daily maintenance. The average maintenance dosage in rheumatoid arthritis is about 1.5 mg. daily.

In Elimination and Reduction of Side Effects

Virtual absence of diabetogenic activity, edema, sodium or water retention, hypertension, or psychic reactions has been noted with DECADRON.[1,2,3,4] Other "classical" reactions were less frequent and less severe. DECADRON showed no increase in ulcerogenic potential, and digestive complaints were rare. Nor have there been any new or "peculiar" side effects, such as muscle wasting, leg cramps, weakness, depression, anorexia, weight loss, headache, dizziness, tachycardia or erythema. Thus DECADRON introduces a new order of magnitude in safety, unprecedented in corticosteroid therapy.

In Therapeutic Effectiveness

With DECADRON, investigators note "a decided intensification of the anti-inflammatory activity"[3] and antirheumatic potency.[4] Clinically, this was manifested by a higher degree of improvement in many patients, previously treated with prednisteroids,[3] and by achievement of satisfactory control in an impressive number of recalcitrant cases.[3,4]

In Therapeutic Range

More patients can be treated more effectively with DECADRON. Its higher anti-inflammatory potency frequently brings relief to cases resistant to other steroids. Virtual freedom from diabetogenic effect in therapeutic dosage permits treatment of many diabetics without an increase in insulin requirements. Absence of hypertension and of sodium and fluid retention allows effective therapy of many patients with cardiovascular disorders. Reduction in the incidence and severity of many side effects extends the benefits of therapy to numerous patients who could not tolerate other steroids. And a healthy sense of well-being, reported by nearly all patients on DECADRON, assures greater patient cooperation.

References:

1. Boland, E.W.: California Med. 88:417 (June) 1958.
2. Bunim, J.J., et al.: Arthr. & Rheum. 1:313 (Aug.) 1958.
3. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.
4. Bunim, J.J., et al.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.

To treat more patients more effectively in all allergic and inflammatory disorders amenable to corticosteroid therapy

DOSAGE AND ADMINISTRATION

With proper adjustment of dosage, treatment may ordinarily be changed over to DECADRON from any other corticosteroid on the basis of the following milligram equivalence:

One 0.75 mg. tablet of DECADRON (dexamethasone) replaces:

↓ One 4 mg.	↓ One 5 mg.	↓ One 20 mg.	↓ One 25 mg.
tablet of methylprednisolone or triamcinolone	tablet of prednisolone or prednisone	tablet of hydrocortisone	tablet of cortisone

SUPPLIED:

As 0.75 mg. scored pentagon-shaped tablets; also as 0.5 mg. tablets to provide maximal individualized flexibility of dosage adjustment.

Detailed literature is available to physicians on request.

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Decadron*

DEXAMETHASONE

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a new order of magnitude in corticosteroid therapy!

The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy



Decadron

DEXAMETHASONE

to treat more patients more effectively

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a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Section 5739.01, Revised Code, contains this provision: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, or rendering hospital or blood bank service. They shall not be required by any provision of Sections 5739.01 to 5739.31, inclusive, and 5741.01 to 5741.22, inclusive, of the Revised Code, to collect sales or use tax on property transferred by them to patients in connection with the rendition of professional services provided that if physicians, dentists, and hospitals are engaged in selling to consumers tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, the tax shall apply to such sales."

CITY PAYROLL TAX

About 30 cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct a percentage of the employee's wages and make returns to the city auditor quarterly. (Refer to March issue of *The Journal,* page 346). A physician who moves into a new location should inquire as to what tax laws may be in force locally.

Homicide Rate Down

In contrast to the marked increase in major crimes, the incidence of homicide in the United States has decreased in the period since World War II, it is reported by statisticians of the Metropolitan Life Insurance Company. The age-adjusted homicide rate fell about one fifth between 1946-47 and 1955-56, from 6.1 to 4.8 per 100,000 of population.

Congress on Industrial Health In Cincinnati, Feb. 16-18

Ohio physicians will have a fine opportunity to get refresher work in industrial medicine at Cincinnati on next February 16, 17 and 18 when the Annual Congress on Industrial Health of the American Medical Association will be held at the Netherland Hilton Hotel.

The theme of the meeting will be "Occupational Medicine — Education, Research and Practice." Dr. Robert A. Kehoe, Cincinnati, is general chairman. Some of the topics which will be discussed are: undergraduate and postgraduate education in the field of industrial health; training fellowships and in-plant training; medical research including toxicology; odor detection, ozone toxicology, noise, radiation, etc. A detailed program will be published in a later issue of *The Journal.*

New National Civil Defense Plan Outlined

Office of Civil and Defense Mobilization, in a 32-page report, has outlined the national plan for civil defense and defense mobilization under three major contingencies: international tension, limited war and general war, including massive nuclear attack. The plan has been promulgated in accordance with Reorganization Plan No. 1 of 1958, which merged Federal Civil Defense Administration with the Office of Defense Mobilization into the new OCDM.

"All citizens and governments at all levels, by virtue of their inherent obligation to support the common defense, are jointly responsible for the civil defense and defense mobilization of the nation," the plan states. The federal government is responsible for direction and coordination of the total national effort; the states are responsible for direction and coordination of activities and its political subdivisions, and local governments for programs of their subdivision.

For disaster services the agency said states and subdivision, with help from Uncle Sam, will stockpile necessary medical supplies and equipment and recruit and train personnel in disaster services.

OCDM Director Leo A. Hoegh said the principles outlined in the national plan would be supported later by a series of 40 annexes, including one on a national medical and health plan. It is being drawn up by the Department of Health, Education, and Welfare which has been given broad responsibilities in the health field in time of national emergency.

Six Poison Centers Serve Ohio . . .

OSMA Committee on Poison Control Recommends that Every Physician Clip This Box and Post It Near His Telephone for Ready Reference

Poison Information Centers in Ohio Currently in Operation

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind:

1. The full name or brand of the product ingested or inhaled or, in the case of plant poisoning, the common and generic name if available.
2. An accurate estimation of the amount of the particular agent ingested or if this cannot be ascertained the maximum amount that could possibly have been ingested.
3. The time of ingestion.
4. The age and weight of the patient.

Pressure for U. S. Medical Aid to Aged Building Up, Official Says

HEW Assistant Secretary Elliot Richardson sees increased pressure on the government for action on health care of the aged. Addressing the American Public Health Association, the No. 3 man in HEW warned: "Unless private, voluntary or local solutions to these and similar problems are found, the pressure for action at higher levels of government will continue to mount." Too few communities, he claimed, have adequate facilities for long-term care of the chronically ill and dependent elderly persons, and very few places pay full costs for the hospital care of the indigent, many of whom are aged.

"For these and other reasons, the cost of health care for the aged has become a political problem of great moment," Mr. Richardson declared. "It will not go away. The real issues center around the degree of public action thereby demanded . . . Some would say that far more federal action is needed; others insist that Uncle Sam is already in too deep."

Mr. Richardson's conclusion: ". . . despite recent progress by private and voluntary institutions in helping the aged to meet the costs of health care, the remaining gaps are serious and difficult to close. The activities of local jurisdiction, moreover, in working out solutions to the health problems of the aged are spotty, sporadic, and for the most part, inadequate."

Two appointments in the American College of Cardiology were announced recently by Dr. J. P. Harvey, governor for Ohio: Dr. Elmer A. Schlueter, deputy governor for the Cincinnati District, and Dr. R. W. Kissane, deputy governor for the Columbus District.

Institute on Steroid Therapy Offered in Columbus

An Institute on Steroid Therapy, sponsored by the Columbus Medical Center Research Foundation, and presented under the auspices of the Department of Medicine of Ohio State University School of Medicine, has been announced for January 8.

Place is the Ohio Union on the Ohio State University Campus and the time, 9:00 a. m. to 5:30 p. m. All Ohio physicians are invited. There will be no fee.

The faculty includes the following guest speakers plus members of the OSU College of Medicine faculty:

Darrell C. Crain, Jr., M. D., assistant professor of clinical medicine, Georgetown University, Washington, D. C.

Leon Goldman, M. D., professor of dermatology, University of Cincinnati.

Dan M. Gordon, M. D., assistant professor of ophthalmology, Cornell University, New York City.

Philip S. Hench, M. D., consultant, The Mayo Clinic, Rochester, Minn.

Bram Rose, M. D., associate professor of medicine, McGill University, Montreal, Canada.

Lewis H. Sarett, Ph. D., chief chemist, Merck Sharp & Dohme Research Laboratories, Rahway, New Jersey.

Details may be obtained by writing: Norman O. Rothermich, M. D., The Columbus Medical Center, 1211 Dublin Road, Columbus 8, Ohio.

The course is eligible for American Academy of General Practice credit.

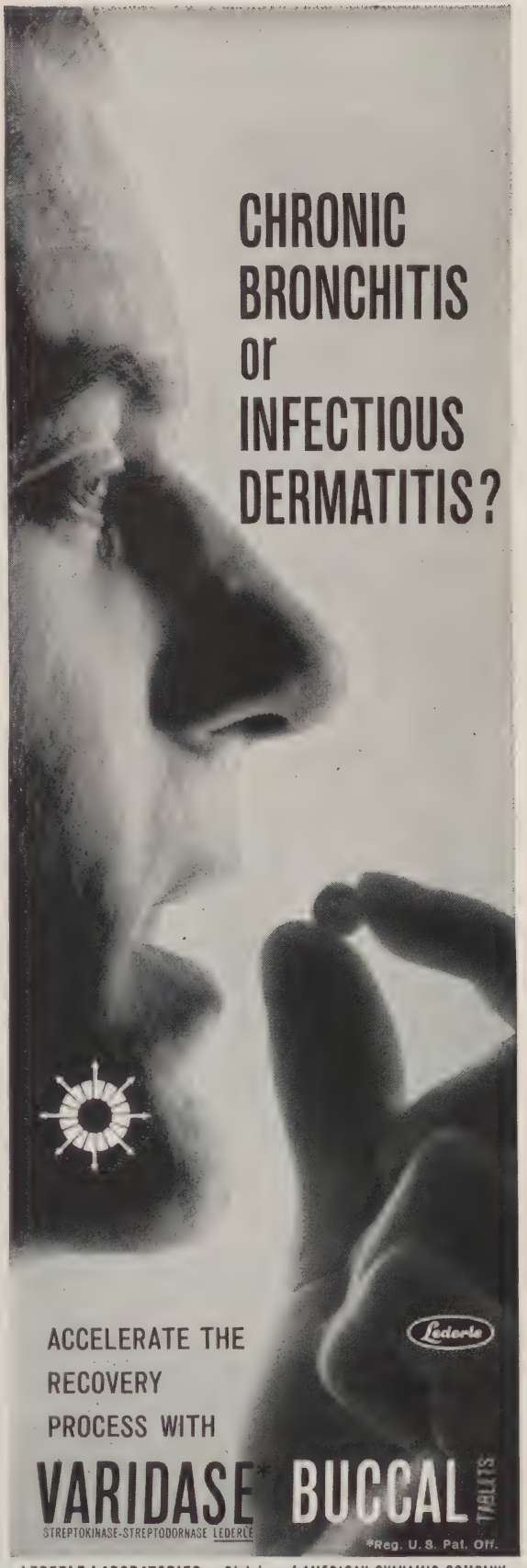
Cincinnatians Participate in Radiological Program

Three Cincinnatians had roles in the Radiological Society of North America meeting recently in Chicago.

Dr. Benjamin Felson, director of the department of radiology, University of Cincinnati College of Medicine, presented a refresher course on "Fundamentals of Chest Roentgenology." Dr. Eugene L. Saenger, UC associate clinical professor of radiology, gave a refresher course on "The Therapeutic Application of Radioisotopes."

Dr. Frederic N. Silverman, UC associate professor of radiology and pediatrics, read a paper on "Congenital Insensitivity to Pain."

Women see physicians more often than men do, especially at the ages of 15 through 44. During childhood, however, boys receive more medical care than girls.—Health Information Foundation.



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since October 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Butler County

John W. Barnes, Middletown
Brady F. Randolph, Jr., Hamilton
Miles M. Vance, Hamilton

Clark County

Edwin A. Roberts, Springfield
David D. Smith, Springfield

Cuyahoga County

Robert B. Ainslee, Cleveland
Robert C. Griggs, Cleveland
George N. Lipsky, Cleveland
Arthur D. Weatherhead, Cleveland

Franklin County

Raymond E. Barker, Columbus
James F. Beattie, Columbus
Peter P. Bosomworth, Waukegan, Ill.
Charles H. Hamilton, Fort Deposit, Maryland
Franklin L. Lyon, Columbus
James F. Mason, Columbus
Richard D. Ruffin, Columbus

Hamilton County

Irving Marcus, Cincinnati
Karel Polesny, Cincinnati
Richard G. Schaefer, Cincinnati

Hancock County

Alfred P. Bukeavich, Findlay
Manuel Sarmina, Findlay

Lake County

Joseph J. Maher, Painesville
Duane N. Tweeddale, Painesville

Lawrence County

Warren N. Morford, Chesapeake

Lucas County

Anthony P. Russo, Toledo

Montgomery County

Thomas C. H. Hwang, Dayton

Wood County

LeRoy J. Eulberg, Pemberville
Jarl B. Nordman, Luckey

Three Institutions Receive H. B. 384 Certification

Three more Ohio institutions were certified by the Ohio Public Health Council October 25 as eligible to obtain from pounds unlicensed, abandoned dogs under provisions of the 1957 Animal Research Act.

They include Christ Hospital Institute of Medical Research, operated by The Elizabeth Gamble Deaconess Home Association, Cincinnati; Maumee Valley Hospital Research Laboratory, Toledo, and Doctors Hospital, Columbus. This brings to 32 the number of institutions so certified since the Act became effective in September of 1957.

Doctors' Radio Service Sought

The AMA has filed a petition with the Federal Communications Commission in Washington requesting that it allocate radio frequencies for the exclusive use of the nation's physicians.

The petition asked the FCC to change its rules so that the medical profession could set up a private two-way mobile radio service of its own which would be known as Physicians' Radio Service.

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

Potentiated Pain Relief

WINTHROP LABORATORIES
New York 18, N. Y. • Windsor, Ont.

Demerol (brand of meperidine), trademark reg. U.S. Pat. Off.

whenever
he
starts
to
CHEW
he's
ready
for
Delectavites®

New vitamin-mineral supplement
in delicious chocolate-like nuggets





There's nothing easier to give
or take–
than Delectavites.
A real treat . . .
the children's favorite . . .
tops with adults, too.

Each nugget contains.

Vitamin A	5,000 Units*
Vitamin D	1,000 Units*
Vitamin C	75 mg.
Vitamin E	2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day
Supplied: Boxes of 30–one month's supply
Boxes of 90–three months' supply or family package.

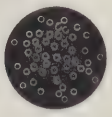
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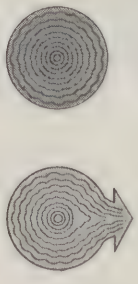
PENETRATES*



SOFTENS FECES



ADDS FORMED BULK



EASES EVACUATION

*Unique encapsulation of millions of minute oil globules by Irish moss assures complete penetrant diffusion in stools.

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TO SOFTEN STOOLS WITHOUT TISSUE DEHYDRATION AND MAKE THEM MOVE WITHOUT STRAINING

KONDREMUL®

COLLOIDAL EMULSION OF MINERAL OIL AND IRISH MOSS patch

PROVEN SAFE...EFFECTIVE • IN PREGNANCY • IN CHILDHOOD • IN MIDDLE-AGED PATIENTS • IN ELDERLY PATIENTS • **THROUGH MORE THAN 25 YEARS OF USE**

AVAILABLE in three pleasant-tasting formulas:

for the average patient
KONDREMUL (Plain)
containing 55% mineral oil. Bottles of 1 pint.

for more hypotonic cases
KONDREMUL WITH CASCARA
0.66 Gm. non-bitter Ext. Cascara per tablespoonful.
Bottles of 14 fl.oz.

for more resistant constipation
KONDREMUL WITH PHENOLPHTALEIN
0.13 Gm. (2.2 gr.) phenolphthalein per tablespoonful.
Bottles of 1 pint.

patch **THE E. L. PATCH COMPANY** Stoneham, Massachusetts

70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Number of Veterans After Reaching Peak Has Begun To Decline

For the first time since the days of World War II the estimated number of veterans in civilian life is showing a consistent downward trend, Sumner G. Whittier, administrator of Veterans Affairs, reported.

There were an estimated 22,723,000 veterans in civil life on September 30, 1958.

Increasing steadily as the servicemen of, first, World War II and then of the Korean Conflict returned from the ranks of the military to civilian pursuits, the number of veterans in the nation reached an all-time high of 22,735,000 in March, 1958.

Up until that time, the number of servicemen becoming veterans during the average month exceeded the number of veterans of all wars who died each month, or who returned to active duty.

The drop to 22,723,000 on September 30 marked the sixth consecutive month the total veteran population had shown a decrease.

The total drop during the 6-month period was 12,000 and was strong indication that, after 19 years of increase, the number of war veterans in the nation was on a downward trend.

Barring another war, the decline will continue without interruption, the Administrator pointed out, unless there should be an unforeseen increase in the discharge rate of Korean Conflict veterans from the armed forces.

Ohio State University Rates High On Aviation Medicine Program

Ohio State University's training of physicians for civilian aviation has placed the United States ahead of other nations in the field, Dr. William F. Ashe, chairman of the Preventive Medicine Department, said in an interview with the public press.

The first civilian residency for aviation medicine, the three-year program for physicians was placed in operation in 1956 and still is the only one recognized by the American Board of Preventive Medicine.

Dr. Ashe, asserting he is "confident" the U. S. has outdistanced Belgium and Switzerland, only early leading contenders, predicted a growing demand for qualified doctors in commercial aviation.

Dr. Ashe started groundwork for the program shortly after his arrival at Ohio State in 1954. The residency program is the product of an aviation physiology laboratory, founded by Dr. Fred Hitchcock in 1941, and an aviation medicine series begun in 1951 under direction of Dr. Richard L. Meiling, associate dean of the College of Medicine.





NEW 3-WAY "PICKUP"
FOR APPREHENSIVE AND/OR
HYPERTENSIVE PATIENTS

NEO-SLOWTEN®
patch

A TRANQUILIZING COMBINATION

- relieves anxiety, irritation, fatigue
- reduces mild elevated blood pressure
- refreshes neural tone

EACH WHITE, SCORED TABLET CONTAINS:
Phenobarbital . . . . . 16.2 mg. (¼ gr.)
Warning: May be habit-forming
Reserpine . . . . . 0.1 mg.
Thiamine hydrochloride . . . . 5.0 mg.

SUPPLIED: Bottles of 100 scored tablets.

patch THE E. L. PATCH COMPANY
Stoneham, Massachusetts

70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, **the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.**

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

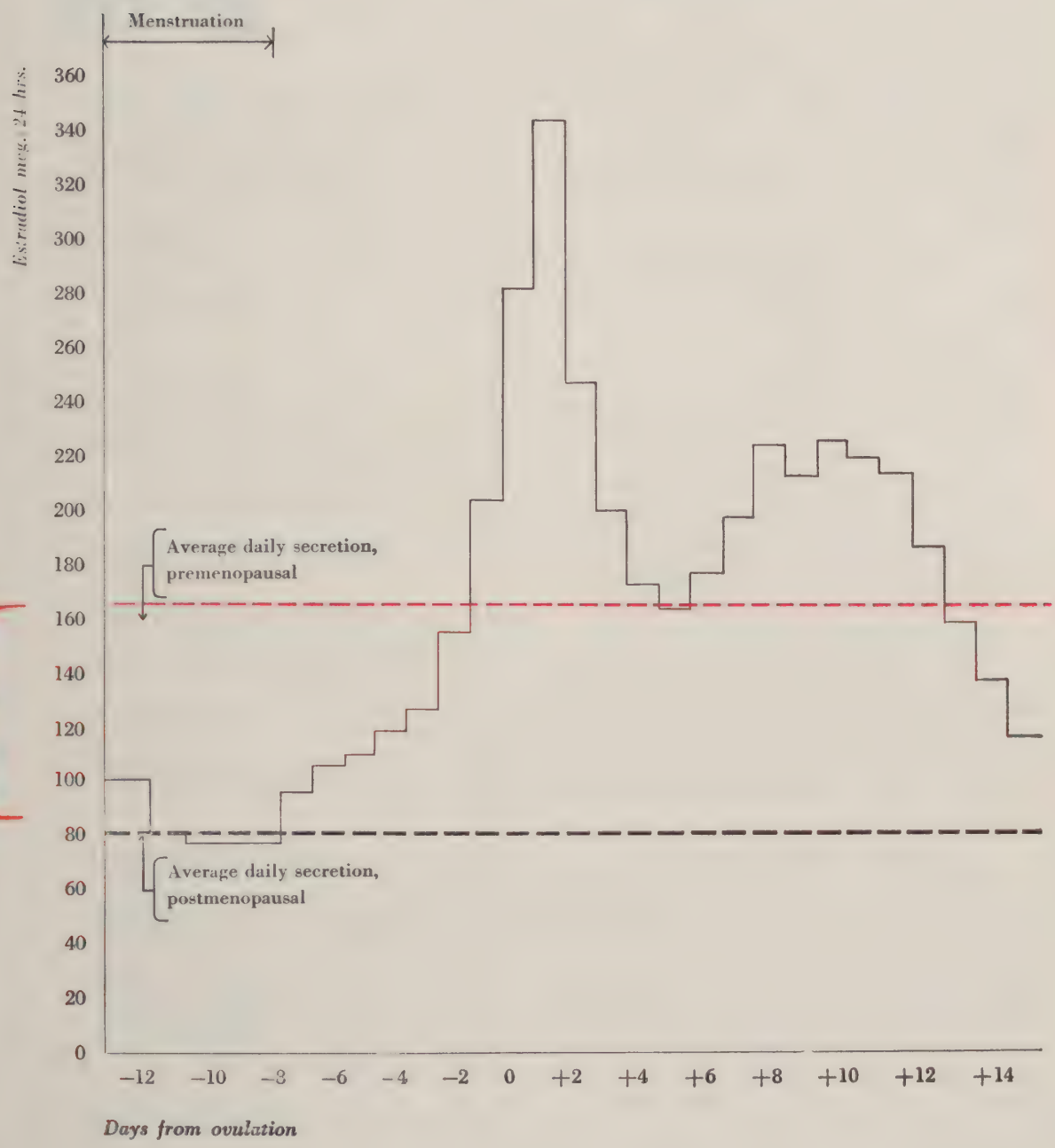
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U.S. PAT. OFF.

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Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)



Ohio Academy of General Practice Elects Officers for Year

The Ohio Academy of General Practice at its recent annual meeting in Toledo named Dr. Lewis W. Cellio, Cincinnati, as president-elect. He will assume the presidency at the 1959 annual meeting in Columbus the week of September 14. Dr. Cellio has been the speaker of the house.

Dr. Charles R. Marlowe, Toledo, was installed as president to succeed Dr. Earl C. Van Horn, Cincinnati.

Other officers and key persons are: Dr. Howard R. Mitchell, Sr., Columbus, re-elected treasurer; Dr. Roger A. Peatee, Bowling Green, speaker of the house; and Dr. Raymond M. Kahn, Dayton, vice-speaker.

New directors are the following: District 1, Dr. Albert D. Weyman, Cincinnati, to succeed Dr. J. Robert Hudson who resigned; District 2, Dr. Paul Troup, Dayton; District 6, Dr. James L. Fisher, Youngstown; District 8, Dr. John Quincy Adams, Jr., Zanesville.

District directors re-elected are: District 4, Dr. Frank M. Good, Toledo; District 10, Dr. William P. Smith, Jr., Columbus.

Hold-over delegates are the following: District 3, Dr. David L. Steiner, Lima; District 5, Dr. Eugene W. Peters, Cleveland; District 7, Dr. Lewis L. Liggett, St. Clairsville; District 9, Dr. William J. Hartlage, Sciotoville; and District 11; Dr. Charles J. Cooley, Oberlin.

Approximately 883 persons attended the annual meeting of which about 538 were physicians.

It's Colder When the Wind Blows and Army Shows How Much with Table

A Wind Chill Table has been designed by the Army to gauge in advance severity of the weather in an effort to further reduce the incidence of cold injury among troops.

Results from the Wind Chill Table are startling. For example, it shows that if the temperature to be expected is about 35 degrees F. and the expected wind velocity is 20 miles per hour, then the effect on exposed flesh is the same as 38 degrees below zero with no wind—the same as being in a deep freeze.

Internists Name Executive

The American Society of Internal Medicine, organized in 1957, will have its first full-time executive secretary January 1. He is Robert L. Richards, Harrisburg, Pa., assistant executive director of the Medical Society of the State of Pennsylvania. Headquarters for the organization is at 350 Post Street, San Francisco 8, California.



have you made your contribution to medical education?

Whether you contribute direct to your Alma Mater or your State or County Medical Society or, through the American Medical Education Foundation —

Why not DO IT TODAY?

american medical education foundation

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In Memoriam . . .

John Alexander Caldwell, M. D., prominent surgeon in Cincinnati for many years and a Past-President of the Ohio State Medical Association, died on November 9 at the age of 81.



Dr. Caldwell

A native of Cincinnati where his father was mayor and Congressman, Dr. Caldwell practiced there from the completion of his medical training to his retirement several years ago. He received his medical degree from the Miami Medical College of Cincinnati in 1902 and did graduate work at Cornell University.

Professor of clinical surgery for many years at the University of Cincinnati, Dr. Caldwell was a diplomate of the American Board of Surgery, member of the American Association for the Surgery of Trauma and Fellow of the American College of Surgeons.

Dr. Caldwell was active for many years in medical organization work. A Past-President of the Academy of Medicine of Cincinnati, he was elected to The Council of the OSMA in 1928 and served as Councilor of the First District before he was named President-Elect in 1933.

After serving as President of the Association in 1935-36 and completing his service on The Council as Past-President, Dr. Caldwell served several years on the Committee on Workmen's Compensation and many years as chairman of the Judicial and Professional Relations Committee prior to his retirement.

He moved from Cincinnati to Burlington, Ky., 13 years ago. Survivors include his widow, a daughter, a son and a sister.

Robert C. Paul, M. D., Wooster, outstanding example of the physician who met the challenges of a rapidly advancing technical age of medicine and science while at the same time upholding the time-honored traditions of the profession, died on October 28 at the age of 97.

Dr. Paul was born in a log cabin at Port Washington before the Civil War. He engaged in several early occupations, began teaching school at the age of 17, read medicine for three years under Dr. Eli Pocock of Shreve and received his medical degree from the University of Wooster Medical Department in 1892. When Dr. Pocock died in 1893, Dr. Paul moved his practice from Fostoria to Shreve and began his long service to the people of Wayne County. He moved to the county seat, of Wooster, in 1914. Dr. Paul practiced a total of 66 years and continued to see patients until less than a year ago.



Dr. Paul

In Wayne County he devoted much time to medical organization work; was a past-president and for many years secretary of the Wayne County Medical Society. He was a member of the Ohio State Medical Association and the American Medical Association. He was honored on numerous occasions for his service to the community by his colleagues and by community leaders, and was a recipient of the OSMA 50-Year Award. Dr. Paul shortly after moving to Wooster helped to incorporate and improve the former Kinney and Knestrick Hospital.

He was active in numerous community affairs; was a 70-year member of the Masonic Lodge, had a 26-year perfect attendance record with the Kiwanis Club, served on the selective service boards during both World Wars, and for many years directed the choir in the local Christian Church. Before the turn of the century he was an officer in the local National Guard Unit. A widower since 1938, Dr. Paul is survived by two nephews.

Elisha Blackburn, M. D., Worthington; University of Wooster, Medical Department, Cleveland, 1903; aged 85; died October 13; former member of the Ohio State Medical Association. Dr. Blackburn began his professional career as a medical missionary for the Friends Church in British East Africa where he served from 1903 to 1916. From 1922 to his retirement in 1950 he practiced in Kalida, Putnam County. Surviving are two daughters and a son, Dr. John H. Blackburn, of Worthington.

George W. Burner, M. D., Johnstown; Columbus Medical College, 1892; aged 95; died October 15; former member of the Ohio State Medical Association. Dr. Burner practiced for many years in the Johnstown area. He was recently making his home with a granddaughter in Marysville. During World War I, he served with the Army Medical Corps in France and later

(Continued on Page 1654)

THE RATIONALE FOR THE USE OF VITAMINS IN FORESTALLING INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall[1] states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production . . . nutrition participates in the prophylaxis against most acute infections . . ."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions . . . Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

THERAGRAN

SQUIBB VITAMINS FOR THERAPY

now expanded to include additional essential vitamins—

and at no extra cost to your patients

Each Theragran Capsule supplies:

Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12} Activity Concentrate	5 mcg.

Dosage: 1 or more capsules daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

Also Available: THERAGRAN Liquid, bottles of 4 ounces; THERAGRAN Junior bottles of 30 and 100 capsules; and THERAGRAN-M (Squibb Vitamin-Minerals for Therapy), bottles of 30, 60, 100 and 1,000 capsule-shaped tablets.

References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

SQUIBB *Squibb Quality—The Priceless Ingredient*

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became an active member of the American Legion. He also was a member of the Methodist Church.

Laurence B. Chenoweth, M. D., Cincinnati; Johns Hopkins University School of Medicine, 1919; aged 67; died October 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Chenoweth retired in 1956 as director of the University of Cincinnati Student Health Service after serving with the university for 36 years. Author of several books in his field, he was a past-president of the American College Health Association; also a member of the Ohio Student Health Association, and a number of other organizations. He is survived by his widow, a son and two daughters.

Oren I. Dusthimer, M. D., Zanesville; Ohio Medical University, Columbus, 1906; aged 82; died October 13; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Zanesville for about 46 years, Dr. Dusthimer devoted a total of 52 years years to his profession, and was a recipient of the OSMA 50-Year Award. Associations included memberships in the Exchange Club and the Presbyterian Church. Surviving are a daughter and a son.

Narvel Howard Foster, M. D., Gallipolis; University of Cincinnati College of Medicine, 1939; aged 50; died October 22; recent member of the Ohio State Medical Association and the American Medical Association. Dr. Foster served all of his professional career in Gallipolis where he was active in numerous civic affairs. He was a past-president of the local Kiwanis Club and former lieutenant governor of the Kiwanis district. Other local organizations in which he was active included the city and county boards of health, the Presbyterian Church, the County Tuberculosis Association and the County Junior Fair. Surviving are his widow, two sons, two sisters and four brothers.

Reuel M. Fullerton, M. D., Lakewood and Bay Village; Western Reserve University School of Medicine, 1924; aged 62; died October 25; member of the Ohio State Medical Association and the American Medical Association. A practitioner for many years in the area, Dr. Fullerton was for 17 years physician for the Lakewood High School. A veteran of World War I, he was active in a number of organizations, among them several Masonic bodies and the Congregational Church. He is survived by his widow, a daughter and his mother.

John P. Harbert, M. D., Bellefontaine; Eclectic Medical College, Cincinnati, 1898; aged 84; died October 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology. A practicing physician in the Bellefontaine area for many years, Dr. Harbert operated a local hospital under his name from 1920 until 1943. He was a former county coroner and took active part in a number of organizations, among them the Red Cross, the Presbyterian Church and several Masonic bodies. Surviving are his widow and two sons.

Sims S. Hindman, M. D., Wyandotte, Mich.; Vanderbilt University School of Medicine, 1900; aged 79; died October 6; former member of the Ohio State Medical Association; member of the American Clinical Society of Pathologists. Dr. Hindman practiced 35 years in Toledo and for 20 years was pathologist for the Riverside Hospital. He retired five years ago and moved first to North Carolina, moving recently to Wyandotte where he made his home with a daughter. Two daughters survive.

Milton E. Jones, M. D., Ocean City, Md.; University of Maryland School of Medicine and College of Physicians and Surgeons, 1915; aged 70; died October 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Jones practiced for many years in Columbus where his specialty was urology. He retired several years ago and moved to Maryland where his widow survives.

Edward J. Kennedy, M. D., Cincinnati; University of Cincinnati College of Medicine, 1913; aged 68; died October 1; former member of the Ohio State Medical Association. A practicing physician in Cincinnati for many years, Dr. Kennedy was serving on the staff of the Veterans Administration Hospital there. He also was former physician for the police and fire departments. He was a veteran of World War I during which he served in Europe. Survivors include his widow, a daughter and three sons.

Edith C. Kline, M. D., Columbus; Woman's Medical College of Pennsylvania, 1905; aged 82; died November 6; former member of the Ohio State Medical Association and the American Medical Association. Dr. Kline practiced medicine in Columbus for 42 years before her retirement in 1947. She was a member of the Methodist Church, the Altrusa Club and the American Association of University Women. Surviving are a sister and a brother, Dr. O. E. Kline, of Westerville.

Pearl D. Longbrake, M. D., Marysville; Ohio Medical University, Columbus, 1897; aged 83; died October 24; member of the Ohio State Medi-

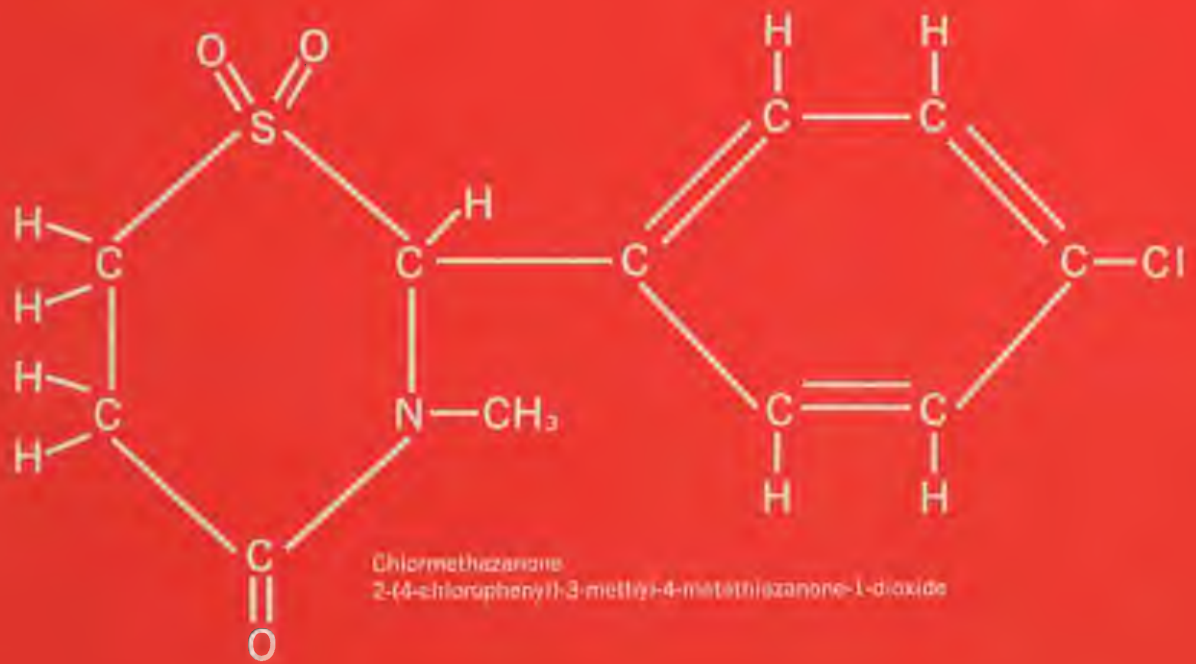
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unrelated chemically to any other drug in current use

designed to be equally effective as both

a MUSCLE RELAXANT

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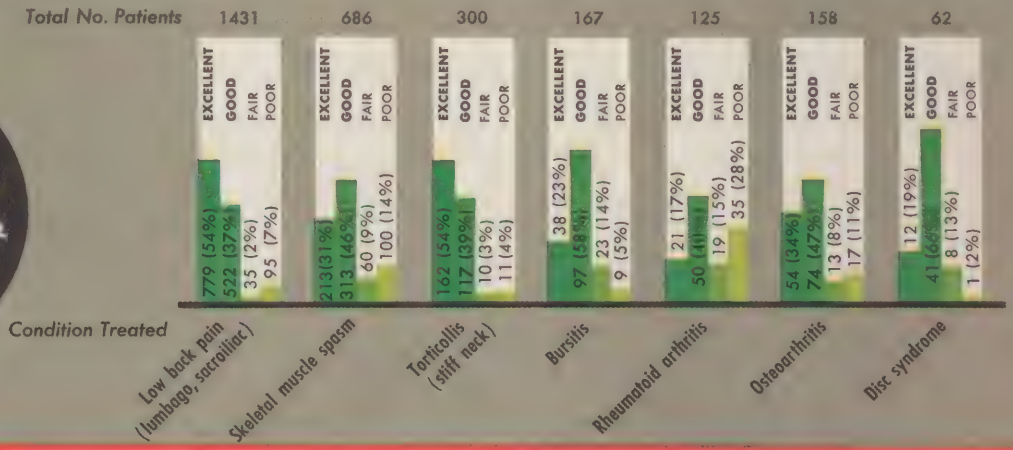
offering new freedom for your patients... from muscle spasm, from tension and anxiety, from side effects

* **tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

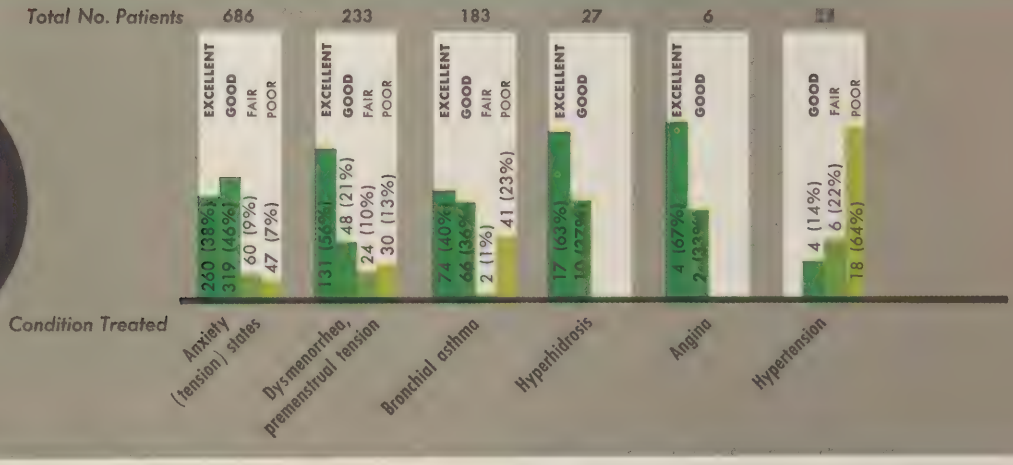
EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtman)

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective when other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.

TRANCOPAL IN MUSCULOSKELETAL DISORDERS



TRANCOPAL IN PSYCHOGENIC DISORDERS



TRANCOPAL . . . the first true "tranquilaxant"

Both a muscle relaxant and a calmative agent.

In musculoskeletal disorders, 91 per cent effective.

In anxiety and tension states, 93 per cent effective.

Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.

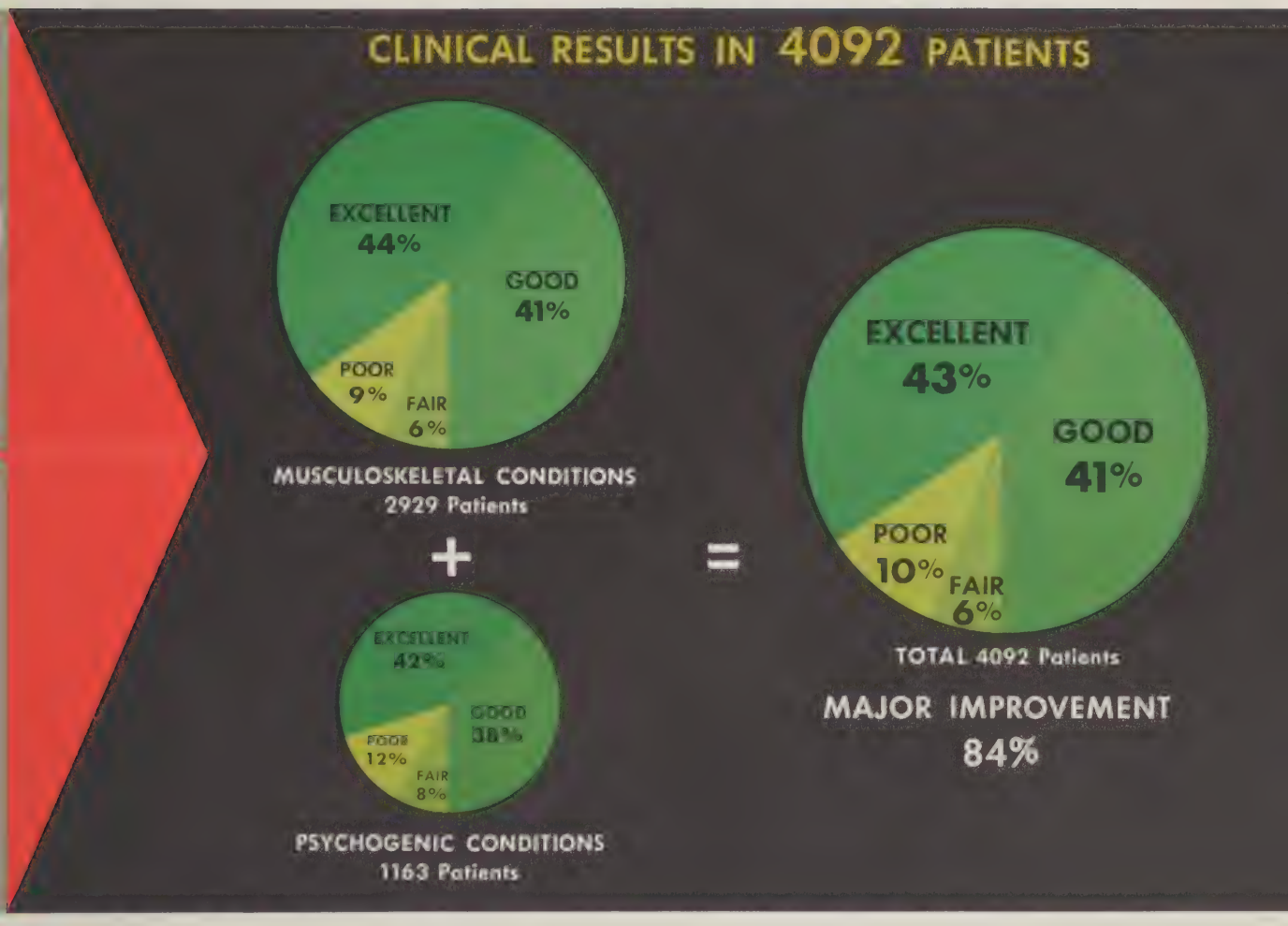
No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.

Low toxicity. In animals, even less toxic than aspirin.

No gastric irritation. Can be taken before meals.

No clouding of consciousness, no euphoria or depression.

No perceptible soporific effect, even in high dosage.



Compare Trancopal with 3 widely used central relaxants

FOR ACTIVITY



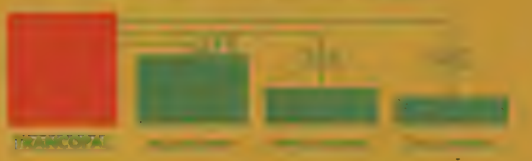
Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.

FOR CLINICAL EFFECTIVENESS



A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated. . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations." (Lichtman)

Trancopal

the first true "TRANQUILAXANT"

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

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• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperative Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, F.: Toxicol. & Appl. Pharmacol. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Surrey, A. R.; Webb, W. G., and Gesler, R. M.: J. Am. Chem. Soc. 80:3469, July 5, 1958.

Printed in U. S. A. 11-58 (392

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

MARCH 2, 3, 4, and 5, 1959

Palmer House, Chicago

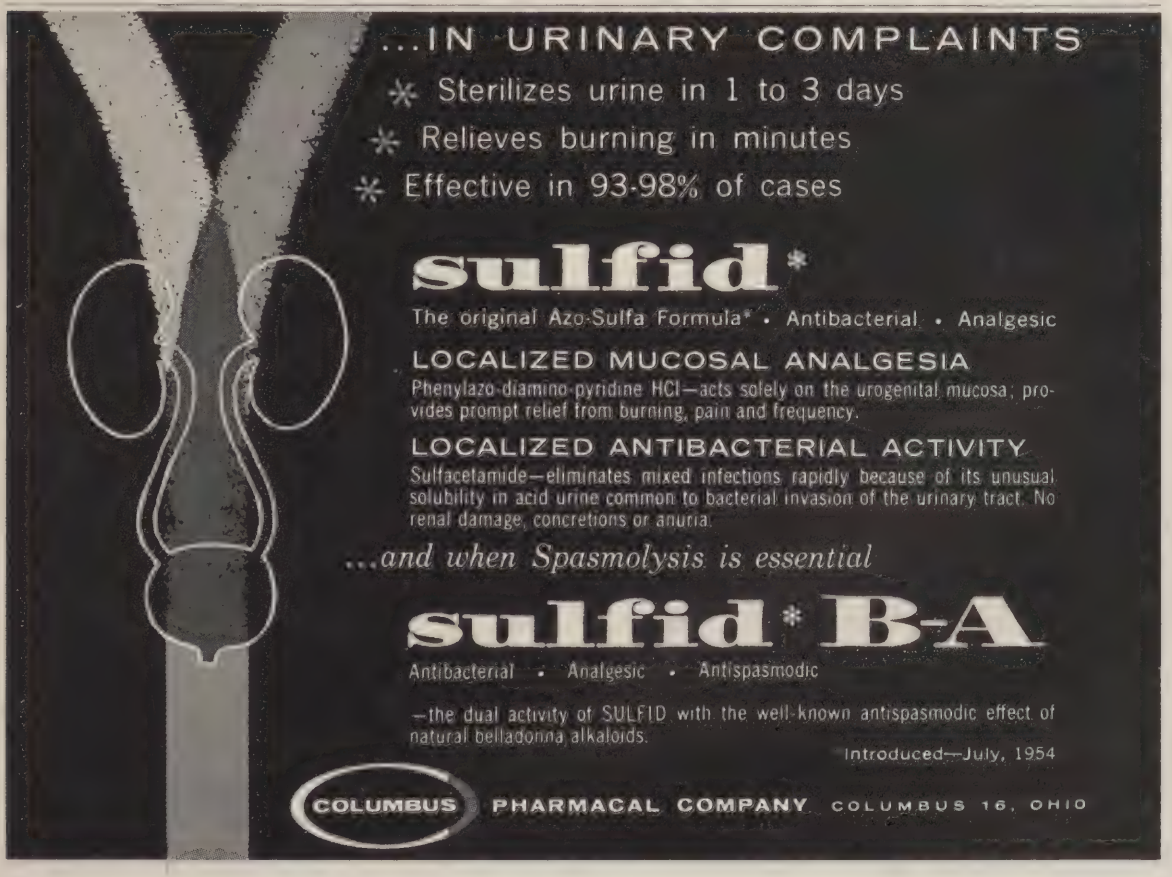
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The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.



cal Association and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Longbrake practiced a total of 62 years, most of that time in his native Marysville. He was active in many community affairs; was a member of the Masonic Lodge and the Methodist Church. He served on the local board of education and formerly was county coroner. Surviving are his widow and two daughters.

Joseph L. Pater, M. D., Hamilton; St. Louis University School of Medicine, 1930; aged 52; died September 30; member of the Ohio State Medical Association, the American Medical Association and the Pan-American Association of Ophthalmologists. Dr. Pater practiced medicine in Hamilton from 1932 to the time of his death, with time out for service in the Army Medical Corps during World War II. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow, a son and a daughter.

Richard T. Pillsbury, M. D., Cleveland; resident physician at the Cleveland Metropolitan General Hospital, aged 25; died October 26; as the result of a boating accident.

Emmet J. Riordan, M. D., Portsmouth; University of Kansas School of Medicine, 1941; aged 43; died November 4; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Riordan had been practicing in Portsmouth since 1954. During World War II he served as Naval flight surgeon and again during the Korean Conflict he served in the Pacific theater. He was a member of the Catholic Church and the Knights of Columbus. Survivors include his widow, three sons, a sister and two brothers.

C. H. Skeen, M. D., Columbia, S. C.; Ohio State University College of Medicine, 1916; aged 65; died October 18; former member of the Ohio State Medical Association. A native of Greenfield, Dr. Skeen practiced there from 1938 to 1948. He previously practiced in Napoleon and Cincinnati. In recent years he became associated with the Veterans Administration and was on the staff of the VA Hospital at Bellingham, Wash., before moving to the VA Hospital in Columbia. A veteran of World War I, he was a member of the American Legion. Surviving are his widow, two sons, three daughters and two sisters.

Carl E. Stein, M. D., Loudonville; Ohio State University College of Medicine, 1932; aged 52; died October 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Stein was a practicing physician in Loudonville for 21 years, interrupting his service there for service in the Army Medical Corps during World War II. He was a member of the American Legion, the VFW, several Masonic bodies, the Eagles Lodge and the Temple. He is survived by his widow, two sisters and three brothers.

Clinton G. Stewart, M. D., Circleville; Rush Medical College, 1912; aged 85; died November 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Stewart practiced in Circleville from 1916 until his retirement in 1952. An ardent golfer, he established the Stewart Cup which is awarded in the Pickaway Country Club each year. Surviving are his widow and a sister.

John W. Viktoryn, M. D., Cleveland; Western Reserve University School of Medicine, 1932; aged 51; died October 22; former member of the Ohio State Medical Association. A native of Cleveland, Dr. Viktoryn served all of his professional career there with the exception of time served in the Army Medical Corps during World War II. He was a member of the Catholic Church and the Holy Name Society. Surviving are his widow, two daughters and two sons.

Harry Ernest Woodbury, M. D., Akron; Western Reserve University School of Medicine, 1915; aged 71; died November 3; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Woodbury practiced in Akron for 40 years, with time out for service in the Army Corps during World War I. During the second World War he was a member of the Ohio National Board. He was a member of several Masonic bodies, the Episcopal Church and the Canton Skeet Club. Survivors include his son, Dr. Jefferson C. Woodbury, also of Akron; also three sisters and two brothers.

Chicago Medical Society To Present Its Annual Conference in March

The Chicago Medical Society's Annual Clinical Conference, to be held March 2, 3, 4 and 5 at the Palmer House, Chicago, will present a program encompassing both "breadth and depth," announced Dr. Coye C. Mason, chairman of the executive committee. Ohio physicians who wish additional information on this traditional postgraduate program are invited to write: Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

Medical Education Fund Benefits from Unusual Business Firm Gift

The Nation's medical schools will this Christmas benefit from a new and unusual type of corporate giving.

In previous years, the Carling Brewing Company of Cleveland sent to its 600-odd distributors individual Christmas presents, whose total cost was about $10,000. This year no individual presents will be sent, but instead that entire sum will be given to the National Fund for Medical Education to be distributed among the medical schools for use primarily in supplementing faculty salaries.

The $10,000 contribution for medical education from Carling's will actually be worth $20,000 because the Ford Foundation matches all "new" money dollar for dollar, given to the National Fund.

The National Fund for Medical Education, founded in 1949 by Dwight D. Eisenhower, then president of Columbia University, former President Herbert Hoover, Dr. James B. Conant and other leading educators, channels contributions from American Industry to the medical schools in the form of unrestricted grants. Since the first grants were made in 1951, it has distributed $15,843,716 to these institutions.

Carling's contribution in behalf of its distributors is over and above their regular annual donation. The company has supported NMEF since 1954.

Congress on Medical Education and Licensure, Chicago, Feb. 7-10

"Specialism in Medicine" will be the theme of the first plenary session when the 55th Annual Congress on Medical Education and Licensure convenes at the Palmer House in Chicago, February 7-10. Following several discussions on the theme, a series of workshop-conferences will focus on specialism in graduate clinical training.

Other session themes will be: "The Role of Research in the Education of all Physicians"; and "The Role of Medical Education in Civilian and Defense Mobilization."

Sponsors of the congress are The Council on Medical Education and Hospitals of the AMA, Advisory Board for Medical Specialties and the Federation of State Medical Boards of the U. S.



Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

CLINTON

Members of the Clinton County Medical Society heard a discussion on investments, securities and estate planning at their luncheon meeting at the General Denver hotel Tuesday (October 7). Raymond Munger of Dayton, in trust planning and insurance business, spoke to the group.

The talks on health given annually at Wilmington high school by doctors were discussed. Doctors plan to continue the series of talks at the school.—Excerpts from the *Wilmington News Journal.*

HAMILTON

The subject of "Hypnotism" was discussed by a visiting panel at the October 7 meeting of the Academy of Medicine of Cincinnati. The panel consisted of Dr. Maurice E. Bryant, Colfax, Wash.; Dr. Milton H. Erickson, Phoenix, Arizona; and Dr. William T. Heron (Ph. D.), Minneapolis, Minnesota.

At the November 11 meeting the subject was "The Hormones of the Posterior Pituitary Gland," presented by Vincent du Vigneaud, Ph. D., Nobel Laureate 1956, professor of biochemistry, Cornell University.

In addition to the regular Academy programs, a number of specialty societies held meetings and conducted programs.

WARREN

For fifty years of devoted practice of the medical profession in the Waynesville area, the Warren County Medical Society in cooperation with the Ohio State Medical Association presented Dr. Mary L. Cook with a plaque at a dinner program at the Golden Lamb, Lebanon, on Wednesday evening (October 22). The presentation for the State Association was made by Dr. Charles M. Hoyt, Cincinnati, Councilor for the First District. Dr. Howard Berninger, president of the local Society, presided.

Ross H. Hartsock, president of the Waynesville National Bank, and a life-long friend of Dr. Cook, spoke in behalf of her friends and neighbors who presented her with 50 gorgeous red roses as a token of their love and esteem. Mr. Hartsock recounted many interesting incidents in the long practice of Dr. Cook.—Excerpts from the *Western Star,* Lebanon.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Dr. Harry Nieman, of Dayton, spoke on "A Survey of 200 Consecutive Cases of Skin Cancer," at a meeting of the Clark County Medical Society in Springfield on October 20.

DARKE

Dr. Norbert Kosater, Dayton, discussed the subject, "Hypnotism in General Practice," at the October 21 dinner meeting of the Darke County Medical Society in Greenville.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Dr. Thomas E. Shaffer, of the Department of Pediatrics, Ohio State University School of Medicine, spoke at the October 21 meeting of the Academy of Medicine of Lima and Allen County on the subject, "Current Status of Staphylococci Infections."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

FULTON

The Fulton County Medical Society met in Archbold on October 21. Dr. Paul F. Orr, Perrys-



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Comprehensive control of constipation with Doxan . . .

★ prevents fecal dehydration and gently stimulates the lower colon in functional constipation

★ synergistically provides, with a subclinical dosage, peristaltic action on a soft, "normal" intestinal content rather than on the hardened mass typical of constipation

★ results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

Doxinate with Danthron (Doxan) is supplied as brown, capsule-shaped tablets containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. 1,8-dihydroxyanthraquinone.

Usual adult dose: One or two capsule tablets at bedtime. Bottles of 30 and 100.

When fecal softening alone is indicated— Doxinate 240 mg.—provides optimal once-a-day dosage for maintenance therapy.

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burg, Councilor for the Fourth District, was present. It was decided to contribute $10.00 per member to the American Medical Education Foundation.

There was a discussion about the County Health Department and the tuberculin skin testing. Members discussed the possibility of doing pre-high school physical examinations and immunizations in the doctors' offices. A committee was appointed to discuss this problem.

The Society decided to sponsor a County-wide essay contest among high school students and offer a $25.00 prize for the best essay on "The Advantages of Private Medical Care."—R. A. Ebersole, M. D., Secretary.

LUCAS

Dr. F. William Sunderman, director of the Division of Metabolic Research, Jefferson Medical College of Philadelphia, was guest speaker for the Inter-Hospital Postgraduate Lecture Series on November 13 and 14. The theme of the series of lectures was "Biochemical Disorders in Disease."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

Dr. Arthur Corcoran, Cleveland, addressed the Ashtabula County Medical Society on October 14. A member of the Cleveland Clinic staff, Dr. Corcoran spoke on the future of heart research, a subject on which he has made extensive study as chairman of the American Heart Association's committee on future needs and facilities for research.

CUYAHOGA

"Alcohol and Liver Disease," was the theme of the October 17 meeting of the Academy of Medicine of Cleveland, co-sponsored by the Cleveland Academy of General Practice. Following are phases of the subject discussed by respective members of a panel:

"Management of Alcoholism in Cirrhosis of the Liver," Dr. A. K. Bochner.

"Surgical Management of Patients with Cirrhosis of the Liver," Dr. Philip Partington.

"Medical Management of Patients with Cirrhosis of the Liver," George Gabuzda.

Moderator of the Panel was Dr. Oscar D. Ratnoff.

Following a social hour and dinner, Dr. Gerald Klatskin, professor of medicine, Yale University, spoke on the subject, "The Role of Alcohol in the Pathogenesis of Cirrhosis."

(Continued on Page 1662)



Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — EARLY 1959

SURGERY—Surgical Technic, two weeks, Feb. 2, Feb. 16. Surgery of the Colon & Rectum, one week, Mar. 2, Apr. 6. Fractures & Traumatic Surgery, two weeks, Mar. 9. Treatment of Varicose Veins, two days, Feb. 2, Mar. 2. American Board Review Course, two weeks, Apr. 6. Blood Vessel Surgery, one week, Mar. 2. Gallbladder Surgery, three days, Mar. 30. Surgery of Hernia, three days, Apr. 2.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 9, Mar. 16. Vaginal Approach to Pelvic Surgery, one week, Feb. 2, Mar. 9. General & Surgical Obstetrics, two weeks, Feb. 23, Mar. 30.

MEDICINE — Electrocardiography, Two-Week Basic Course, Mar. 16. Gastroscopy & Gastroenterology, two weeks, Mar. 2. American Board Review Course, one week, Apr. 20.

UROLOGY—Two-Week Intensive Course, Mar. 30. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Mar. 2, Apr. 27. Clinical Uses of Radioisotopes, two weeks, May 4.

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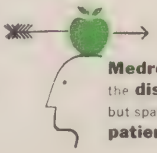
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First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

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Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

A husband and wife team from Johns Hopkins School of Medicine, presented the scientific program for the November 4 meeting of the Summit County Medical Society in Akron. Dinner was served at the Akron City Club after which the meeting was held in the Akron City Hospital Auditorium. The subject discussed was hermaphroditism.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

COLUMBIANA

Dr. Penn G. Skillern, Cleveland, was speaker at a meeting of the Columbiana County Medical Society on October 14 at the Hotel Wick in Lisbon. He discussed "Current Management of Diabetes."

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

FAIRFIELD

Fairfield County Medical Society members agreed at a recent meeting that one doctor each month would handle cases reported to the Well Child Clinic of the City Health Department in Lancaster.

Dr. Howard Sirak, on the staff of Children's Hospital, Columbus, spoke before the group discussing surgery as it pertains to rheumatic and congenital heart conditions.

The Society exhibited at the Fairfield County Fair. Dr. William Jasper, chairman of the Society's public relations committee, arranged an exhibit of antique medical and surgical equipment.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Nearly 400 reservations were received for this year's "P. R. Institute for Medical Assistants" held Wednesday, October 8, 1958, at the Ohio Union, on the Ohio State University Campus.

Doctors Homer A. Anderson, George D. Clouse and Paul R. Leithart with Stanley R. Mauck, Executive Director of the Columbus Bureau of Medical Economics, as Chairman comprised the committee responsible for the program.

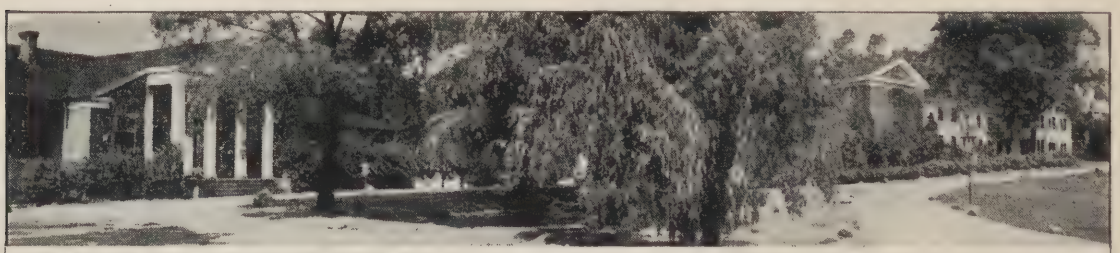
The theme of the meeting was "The Public Relations Factor in Telephone Communications" and featured three speakers. Dr. Thomas R. Curran discussed "The Use of the Telephone—as observed by the Professional Relations Committee" and was followed by Stanley R. Mauck on the subject "The Use of the Telephone—as observed by the Medical Bureau." The guest speaker for the evening was Miss Helen Kiess, Service Consultant for the Ohio Bell Telephone Company who presented an interesting and informative talk entitled "The Telephone—Friend or Foe." A lively question and answer session followed the program which highlighted some of the everyday problems encountered in the physician's office involving use of the telephone.—*Bulletin of the Columbus Academy of Medicine.*

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ERIE

Dr. Samuel R. Gerber, Cleveland, coroner of Cuyahoga County, was speaker at a joint meeting of the Erie County Medical Society and the Auxiliary at the Ontario School. Dr. Gerber spoke on the subject, "Automotive and Traffic Safety."



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Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Representatives of other groups in the area interested in safety were present.

LORAIN

The regular meeting of the Lorain County Medical Society was held Tuesday, October 14, at Oberlin Inn, preceded by a social hour and dinner. The program of the evening was given by Dr. George J. Thomas, director of the Department of Anesthesiology, St. Francis Hospital, Pittsburgh, Pa., who gave an excellent lecture and demonstration on "Hospital Hazards," alerting all to the necessity for constant vigilance to assure safety in anesthetizing areas.

In recognition of their interest in this subject, area hospital administrators, fire chiefs, operating room supervisors and nurse anesthetists were invited as guests of the Society, and welcomed and introduced by Dr. Ben V. Myers, president. Fifty physicians and 20 guests were present.

In the regular meeting prior to the lecture, Charles C. Brausch, M. D., of Avon Lake, was elected to Associate Membership, and Iwan Czornyj, M. D., of LaGrange, elected to Active Membership.

Dr. Valloyd Adair gave a memorial address for the late Charles R. Meek, M. D., of Lorain, and the group paid a standing silent tribute to his memory.

Reports were given by Paul J. Kopsch, chairman of Legislative Committee; John W. Wherry, chairman of Insurance Committee; and Ben V. Myers on behalf of O. H. Schettler, chairman of Committee for Liaison with County Welfare, and Joseph M. Strong, Social Committee chairman, responsible for the recent clambake.

Dr. H. T. Pease, councilor of the eleventh district, was welcomed by the Society, and reported on various matters of interest.

Dr. Ben V. Myers announced the members of the New Education Committee. James T. Stephens of Oberlin has consented to be chairman, with Roy E. Hayes (Elyria), Charles Butrey (Lorain), John R. Bay (Oberlin) and William Wladecki, Elyria).

The Nominating Committee was appointed to prepare a slate of officers for presentation at the November meeting. Dr. James T. Stephens will serve as chairman, with T. L. Smith and R. D. Berkebile.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

Orthopaedic Society

A meeting and program has been scheduled by the Ohio Orthopaedic Society to be held in Akron, April 10 and 11, 1959. Further details will be announced. Committee on arrangements may be contacted by writing James G. Roberts, M. D., 655 W. Market St., Akron 3, Ohio.

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This new timed-release tablet provides:

- ***...the superior decongestant and antihistaminic action of Triaminic***
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- ***...the specific antipyretic and analgesic effect of well-tolerated APAP***
- ***...the prompt and prolonged activity of timed-release medication***

Each* TUSSAGESIC *Tablet contains:

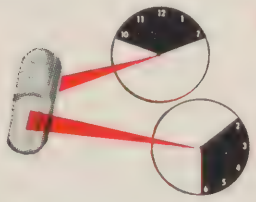
TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.;
pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
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Terpin hydrate	180 mg.
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Medicare Office Issues Policy Regarding Special Permit

The Washington office of Medicare on October 21 issued the following statement of policy regarding Medicare Permits:

Inquiries have been received as to whether an eligible dependent who commences receiving authorized care from a civilian source participating in the program, who is *residing apart from the sponsor* at the time the care commences, and who *takes up residence with the sponsor* before completion of that care, may continue that care from that source without obtaining a Medicare Permit. As a general rule, such care may be continued without a Medicare Permit. Guidance for administration of the rule in certain specific instances is set forth below:

a. An eligible dependent spouse or child who is *hospitalized* for care authorized under the program, who is "Residing Apart from Sponsor" at the time of admission, and who acquires the status of "Residing with Sponsor" during hospitalization, may complete authorized hospital care for that admission and for readmissions indicated under Section 5-506g of the Joint Directive without a Medicare Permit. That Section covers readmissions within 14 days following discharge from the previous admission, for authorized treatment of the original condition for which initially hospitalized, or direct complications thereof.

b. An eligible dependent who is "Residing Apart from Sponsor" at the time *maternity care* is commenced, and who takes up residency with her sponsor during the period of the care and prior to hospitalization for delivery or for complications of pregnancy, would not be in a position to certify on the hospital claim form "Residing Apart from Sponsor—Yes." Also, she would not be in a position to make such a certification on claim forms of other approved sources of care. However, if she does not change her attending physician, she may obtain required hospitalization and other required care from approved sources without a Medicare Permit, provided the person signing Item 14 on the DA Form 1863 furnishes the hospital a written statement, on the claim form or attachment thereto, that maternity care for the pregancy or complications thereof for which hospitalized was commenced on a date when she was residing apart from the sponsor. If such an eligible dependent changes her attending physician for any reason (other than death or illness of her attending physician), she must secure a Medicare Permit in order to obtain authorized care from civilian sources at Government expense. In those instances where a change of attending physician has occurred due to the death or illness of the attending physician, that fact should be stated on the claim form or attachment thereto by the person signing Item 14 on the DA Form 1863. Of course, any eligible dependent may obtain required care from a uniformed services medical facility, if available.

Nine Steps To Curb Staph Infections in Hospitals

On the basis of findings and recommendations of the National Conference on Staphylococcal Disease held in Atlanta, the following measures are proposed by the Public Health Service to prevent and control hospital outbreaks:

1. Establish infectious control committees in all hospitals.

2. Employ an "infection log" for entering and classification.

3. Screen staff personnel who have boils or who are carriers.

4. Exercise discrimination in use of antibiotics.

5. Store cultures from staph infections.

6. Isolate infectious patients.

7. Take special precautions in nurseries for newborn.

8. Stress training of personnel, intensively and continuously.

9. Strengthen laboratory services and expand research.

Youngstown Physician Is Honored By Jaycees for Community Service

Dr. John N. McCann, Youngstown, active civic, religious and medical leader, was presented the Sixth Annual Frank Purnell Award by the Junior Chamber of Commerce Tuesday night (Oct. 28).

Dr. McCann was honored at the Jaycee's 24th annual Bosses' Night Dinner at Hotel Pick-Ohio, attended by more than 300 industrial, business and civic leaders.

Among Dr. McCann's outstanding contributions to Youngstown and vicinity, have been service to the YMCA, Youngstown University, the Mahoning County Tuberculosis Hospital, St. Elizabeth Hospital and many Youngstown Diocese Catholic charities.

Dr. McCann is president of the Ohio State Medical Board and is a member of the executive committee of St. Elizabeth Hospital. He has been a board member 25 years of the YMCA and is serving on the board of trustees of Youngstown University.—Excerpt from the *Youngstown Vindicator.*

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(See Page 1541 for roster of officers.)

ALLEN

Lima and Allen County Medical Auxiliary was hostess to the Third District of Ohio at a luncheon meeting on October 22 at the Lima Club. Mrs. Charles Blumstein, President, introduced Mrs. Stephen Churchill of Kenton, Third District Director, who in turn presented the following state and district officials: Mrs. Rivington Fisher of Columbus, Tenth District director; Mrs. L. W. Sontag, Yellow Springs, State Public Relations director; Mrs. R. D. Hendrickson of Xenia, Second District director; Mrs. G. T. Harding III of Worthington, state first vice-president; Mrs. C. H. Bell of Mansfield, state president.

Mrs. Bell was the main speaker of the afternoon. Mrs. H. C. Kingsbery is Program Chairman.

COSHOCTON

The annual meeting of the Seventh District of the Woman's Auxiliary of the Ohio State Medical Association was held October 14 at the Town and Country club, with the Woman's Auxiliary of the Coshocton County Medical Society as hostess.

Following the luncheon Mrs. Norman L. Wright, president of the local group, greeted the guests. A musical program was presented by Mrs. Olan Aughbaugh.

Mrs. C. F. Goll, Steubenville, District director, introduced the state officers and presidents of Jefferson, Tuscarawas and Coshocton counties.

Mrs. C. H. Bell, state president, reviewed the national convention held in June in Los Angeles. She emphasized the priority projects for the year, and concluded with the national slogan, "Safeguard Today's Health for Tomorrow."

Mrs. Floyd W. Craig was chairman for the luncheon.

ERIE

The Woman's Auxiliary to the Erie County Medical Society had its first meeting September 15. The Auxiliary members were luncheon guests at the home of Mrs. C. E. Swanbeck, Huron. Mrs. Swanbeck, a past-president, is Erie County's representative in the Ohio Legislature and a member of the house committee on Education, Welfare, Commerce and Transportation.

The luncheon was served in authentic Swedish style, and in the same manner that Dr. and Mrs. Swanbeck enjoyed on their recent tour of the Scandinavian countries. During her trip she surveyed government bodies, common problems in geriatrics, education, housing and retarded children, as compared to those of the U. S. After the luncheon, Mrs. Swanbeck gave a most interesting talk concerning these problems.

The October meeting of the Woman's Auxiliary to the Erie County Medical Society was a joint meeting with the Erie County Medical Society. The speaker was Dr. S. R. Gerber, Cleveland, coroner of Cuyahoga County, who spoke on the subject "Automotive and Traffic Safety." Safety is being stressed by the Ohio State Medical Association and all county auxiliaries were asked to cooperate in giving a program of this type. Special invitations were issued to interested persons and organizations. These included, AAA, city and county High School driver's trainer clubs, sheriff of Erie County, highway patrol, safety director in all service clubs, county coroner and assistants, police chief, newspaper and radio representatives. Refreshments and a social hour followed.

The public relations committee offered as a public service the processing of absentee ballots to persons physically unable to go to the polls on election day.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Association was invited to the home of Mrs. William Boswell, Baltimore, for a luncheon meeting.

Mrs. G. F. Jones, president of the group, presided for this business meeting.

A statement was presented by Mrs. William Jasper in regard to the transportation for student nurses from Lancaster-Fairfield Hospital to the Branch College for affiliate work. Auxiliary members have been providing this transportation in private cars. The Auxiliary agreed to provide funds for commercial mode of transportation, as an emergency measure.

Mrs. F. A. Dowly reported that recreational facilities and equipment authorized by the Woman's Auxiliary had been provided for the student nurses.

Mrs. C. R. Reed was chairman for the annual Halloween party for the student nurses.

Social Hour followed the business session. Mrs. Oscar Jepson, honorary member, and Mrs. C. B. Crow, prospective member, were guests at this meeting.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine had a luncheon meeting on

October 20 in St. Stephen's Episcopal Church, Columbus.

Dr. Lloyd M. Parks, dean of the College of Pharmacy, Ohio State University, was the speaker. His topic was "The Dangers of Self Medication."

Presidents and Medical Auxiliary members of the Tenth District from Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross and Union counties were invited to attend. Special guests included Mrs. C. H. Bell, Mansfield, state president; Mrs. C. A. Colombi, Cleveland, state president-elect; and Mrs. Karl F. Ritter, Lima, state chairman, American Medical Education Foundation. Mrs. Rivington Fisher, Columbus, is the director of the Tenth District.

Mrs. Nicholas Michael, social committee chairman, was assisted by Mrs. I. Darin Puppel, Mrs. M. L. Phillips, Mrs. Jack Tetirick, Mrs. Albert Kostoff, Mrs. Ralph Johansmann, and Mrs. James Hardie.

An Executive Board meeting was held in the Church Lounge. Mrs. George O. Kress, president, presided.

HAMILTON

The Woman's Auxiliary to the Academy of Medicine of Cincinnati met on November 3. Once again the Auxiliary did a splendid job with its Disabled Voters Committee. Thirty-five auxiliary notaries voted approximately 250 patients in 8 Cincinnati Hospitals. Mrs. James B. Street, Vice-Chairman of this committee, carried on in the absence of the chairman, Mrs. William C. Schmidter.

In November the local Auxiliary held its annual dinner dance for the benefit of the philanthropic fund. "The Harvest Moon Ball" was held in the Pavillon Caprice of the Netherland Hilton Hotel under the general chairmanship of Mrs. William P. Jennings. Cocktails preceded dinner which was followed by dancing.

The sale of Christmas cards for the benefit of the AMEF is proceeding with great success under the chairmanship of Mrs. Robert B. Krone.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society opened its Fall season with a luncheon at Squaw Creek Country Club on Sept. 9. Mrs. Earl H. Young presided.

Mrs. Myron Hanysh, membership chairman, welcomed 13 new members. The guest speaker was Father Anthony of Saints Peter and Paul Church who reviewed Tito's rise to power in Yugoslavia.

An Auxiliary bowling league has been organized with Mrs. Edward A. Shorten as chairman.

Members of the Auxiliary acted as hostesses

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when the Mahoning County Medical Society staged its commemoration banquet September 27 honoring 27 past-presidents. Two hundred doctors and their wives attended. The speaker was Dr. George F. Lull, assistant to the president of the American Medical Association, who urged physicians to take a more active part in community problems.

"Chapeaux for You" was the title of the millinery style show presented at the October 7 luncheon meeting at the Jade Room for Auxiliary members and their guests.

MUSKINGUM

A meeting of the Eighth District Medical Academy Auxiliary was held October 2, at the home of Mrs. William B. Smith. Fifty-two members attended a tea which was followed by adjournment to the Zanesville Country Club. At the club Mrs. James Morton, president of the local auxiliary, introduced three visiting officers of the Ohio Auxiliary: Mrs. C. H. Bell of Mansfield, Mrs. George T. Harding III of Worthington, and Mrs. J. R. Wells of Newark. Entertainment followed which was a farce fashion show given by members of the Muskingum County Medical Auxiliary. The women then joined their husbands, who had been spending the day at the Academy District meeting in Zanesville, for dinner. The dinner was highlighted by a talk "Unsolved Murders" given by Dr. Alan Moritz from Western Reserve University.

OTTAWA

The Auxiliary to the Ottawa County Medical Society has already accomplished many feats.

During the Oak Harbor Fair and Fall Festival the Auxiliary had a Health Booth. Our members took turns staffing the booth and giving to the public free Health Record books, wallet cards, and samples of *Today's Health.*

October 21 a rummage sale was held in Port Clinton, the proceeds of which will be used for projects of the hospital.

October 28 the annual Nurse Recruitment Tea was given. All sophomore girls of the county were invited. This year the film "Helping Hands for Julie," was shown to interest students in the opportunities and rewards of careers in nursing and the allied professions.

On October 31 members of the Auxiliary took Halloween favors to the hospital and to a county nursing home.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met for a meeting and tea at the Women's Club, Mansfield. Forty-three members were present.

Mrs. Robert Tawse stated that a student nurse at Mansfield General Hospital had need for and was now using the Auxiliary sponsored scholarship. She also stated that the Future Nurses Club looks most promising with 28 members present at the last meeting.

Reports from the State Conference meeting held in Columbus, and from the District Meeting held in LeRoy, were given.

After all business was taken care of the meeting was turned over to Mrs. Charles Butner who acted as Mistress of Ceremonies for the program that followed in honor of Mrs. C. H. Bell, the State Auxiliary President.

Mrs. J. L. Stevens told of the early formation of the local and state auxiliary and gave a few highlights of the year she was State Auxiliary president.

The meeting was adjourned by Mrs. Butner and a tea followed.

STARK

Twenty new members of the Woman's Auxiliary to the Stark County Medical Society were present at a tea October 14 at the home of the president, Mrs. Ralph K. Ramsayer. Mrs. Richard Skibbens, membership chairman, was in charge of the arrangements and introduced the new members to the auxiliary board. Mrs. Richard Spitzer, immediate past-president, and Mrs. Lloyd Dowell of Massillon, president-elect, presided at the tea table.

The first meeting of the Auxiliary was held in Alliance at the Alliance Women's Club on October 21. Mrs. James J. Thomas was chairman of the meeting and Mrs. William A. McCrea, co-chairman. A musical program was given by Mrs. Cecil Stewart.

The Annual Benefit Dance sponsored by the Auxiliary for the benefit of the nurses' scholarship fund was discussed. The rotating scholarship for nurses was established by the auxiliary in 1937. Since that time 50 students have been given assistance in their nursing careers. The total value of the loans given students in area schools of nursing amounts to $13,680. These funds are raised primarily from the annual dance. The committee is headed by Mrs. Murray W. Scott, Jr., assisted by Mrs. J. George Tifft as co-chairman.

SCIOTO

The District 9 meeting of the Woman's Auxiliary to the Ohio State Medical Association was held in connection with the 18th birthday anniversary celebration of the Woman's Auxiliary of Scioto County Medical Society at the Elks City Club auditorium.

Mrs. George W. Cooper of Waverly, district director, presided at the afternoon luncheon at which past-presidents of the local group served as

hostesses under the chairmanship of Mrs. Samuel L. Meltzer.

The state president, Mrs. C. H. Bell, of Mansfield, was the afternoon speaker.

Dr. Carter L. Pitcher, chairman of the state advisory committee to the auxiliaries and district Councilor of the Medical Association, and Dr. S. L. Meltzer, president of Scioto County Medical Society, also gave short talks.

The District 10 director, Mrs. Rivington Fisher of Columbus, also was a guest. County presidents attending included Mrs. Alvis Hambrick of Jackson, Mrs. Ralph Massey of Lawrence, Mrs. Robert Lever of Pike and Mrs. Armin Melior of Scioto.

The entertainment featured O. T. (Sandy) Dresbach, Mrs. F. Carl Deshler, Mrs. J. Edward Doerr and Mrs. Franklin Page, who presented "Behind the Scenes in Radio."

Grant Reed, president of Scioto County Cancer Society, presented Mrs. Daehler with an award of merit for extraordinary service in the crusade to conquer cancer.

SUMMIT

Sixth District Postgraduate Day Meeting was held in Akron on October 22. Mrs. John Brumbaugh was chairman of the committee to entertain the visiting wives, with Mrs. Robert G. McCready as co-chairman. The agenda began at 8 a. m. in the Sheraton Hotel with a continental breakfast served to the visitors as they arrived and registered.

Visitors and members of the Akron Auxiliary were entertained at luncheon at the Women's City Club with a program by Joe Portaro, hair stylist of Cleveland.

The day ended with a banquet for the doctors and wives in the Sheraton Hotel. Mrs. M. F. Bossart and Mrs. J. Walter Johnson, assisted by their committee, were in charge of reservations. The hostess committee was in charge of Mrs. Uffe Jensen.

Mrs. C. A. Colombi, president-elect of the Ohio State Medical Auxiliary, and Mrs. Edward Bauman, director of the Sixth District, presided at the business meeting.

The Woman's Auxiliary to the Summit County Medical Society held a brunch meeting at the Portage Country Club on November 4. Members and their guests heard a very interesting and enjoyable talk by Dr. Nicholas Dallas of Toledo, creator of Rex Morgan and Judge Parker.

TRUMBULL

The Auxiliary to the Trumbull County Medical Society met for lunch at the Squaw Creek Country Club on October 14. Miss Marie O'Rourke, dean of Girls at Harding High School in Warren, was



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the guest speaker. Her subject was "Preparing Your Child for College."

The short business session was conducted by the president, Mrs. John Grima. Attention was called to the District Meeting and to the radio program "Child Development," sponsored by the Auxiliary over the local radio station. Mrs. E. R. Westbrook, Mrs. L. A. Claitsman, and Mrs. E. G. Caskey took part in the radio program.

The Trumbull County Bar Auxiliary entertained the Medical Auxiliary at an evening meeting at the Warner Hotel on October 23. Margaret Spithaler spoke on the subject, "Do It Yourself." The Medical Auxiliary entertained their husbands at a Crazy Hat Square Dance on October 29. Mrs. J. E. Burns and Mrs. J. Williams were chairmen at this party.

National Conference on Aging Is Planned for Spring of 1959

Plans are currently being developed for a national conference on the health problems of the aged, to be held in the spring of 1959 under the sponsorship of the Joint Council for the Health Care of the Aged, Mrs. Florence L. Baltz, Washington, Ill., newly elected chairman of the Council, has announced.

"Such a conference will provide the basis for more effective joint planning on the part of those who are the principal purveyors of health care for the aged," Mrs. Baltz, incoming president of the American Nursing Home Association, pointed out.

The Joint Council was formed last April under the sponsorship of the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association.

Its objectives are to (1) identify and analyze the health needs of the aged, (2) appraise available health resources for the aged, (3) develop programs to foster the best possible health care for the aged, (4) foster effective methods of payment for the health care of the aged, and (5) foster health education programs of the aged.

Twelve directors of the Joint Council, three from each of the four sponsoring organizations, were elected at an incorporation meeting held on October 25.

The new directors, in addition to Mrs. Baltz, are:

Dr. Louis M. Orr, Orlando, Fla., president-elect of the American Medical Association and vice-chairman of the Joint Council; Dr. Gunnar Gundersen, LaCrosse, Wis., president of the AMA; Dr. F. J. L. Blasingame, Chicago, executive vice-president of the AMA; Dr. W. R. Alstadt, Little Rock, Ark., president of the American Dental Association; Dr. Harold Hillenbrand, Chicago, secretary of the ADA; and Bernard J. Conway, Chicago, secretary of the ADA's Council on Legislation.

Others are: Tol Terrell, San Angelo, Tex., immediate past-president, American Hospital Association; Ray Brown, Chicago, AHA past-president; Dr. Edwin L. Crosby, Chicago, director of the AHA; Ira O. Wallace, New Castle, Ky., president of the American Nursing Home Association; and Frank C. Bateman, Washington, D. C., executive director, ANHA.

Howard I. Wells, Jr., executive secretary of the Joint Council, was elected secretary-treasurer.

Two Ohio Physicians and Layman Honored at Heart Meeting

An Ohio physician became president-elect of the American Heart Association at that organization's annual meeting, another Ohio physician was honored with a top award and an Ohio layman was named to a top executive post.

Dr. A. Carlton Ernstene, chief of staff of the Division of Medicine, Cleveland Clinic, was named president-elect of the American Heart Association at the Annual meeting in San Francisco. He will assume the office of president at next year's annual meeting, succeeding Dr. Francis L. Chamberlain of San Francisco. Dr. Ernstene was vice-president of the AHA for 1957-1958.

A past-president of the Ohio State Heart Association and of the Cleveland Area Heart Society, he has been a member of the AHA's board of directors since 1953 and has served as chairman of the Council on Clinical Cardiology and of the Policy Committee. A director of the American Society for the Study of Arteriosclerosis, Dr. Ernstene is also a member of the editorial board of *Circulation,* professional publication of the Heart Association. For several years Dr. Ernstene has been chairman of the Committee on Scientific Work for the Ohio State Medical Association, the committee which has charge of arrangements for the OSMA Annual Meeting.

Dr. Irvine H. Page, also of Cleveland, was awarded the 1958 Albert Lasker Award of the AHA for distinguished achievement in the field of cardiovascular research. The award to Dr. Page honors especially his many contributions to greater scientific understanding of hypertension and its underlying mechanisms.

Walter S. Page, Jr., of Columbus, executive director of the Ohio State Heart Association, was installed as president of the national Staff Conference of Heart Associations. The 800-member organization includes professional heart association workers from the United States and Canada.

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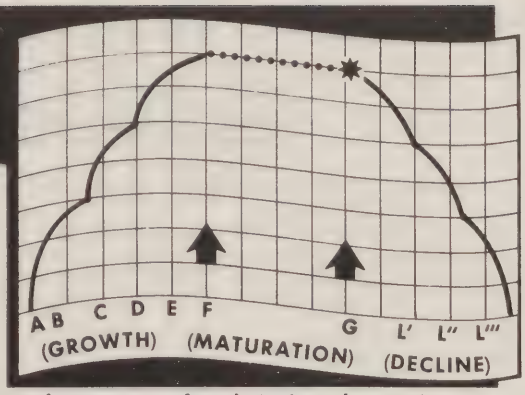
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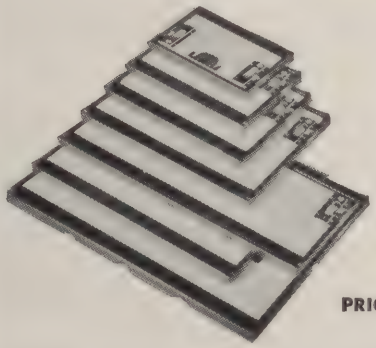
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Five Physicians on Ohio Committee To White House Conference

Five Ohio physicians have been appointed by Gov. C. William O'Neill to a 49-member committee to represent Ohio at the National White House Conference on Children and Youth in 1960.

They are: Dr. Thomas E. Shaffer, Columbus, chairman, Committee on School Health, Ohio State Medical Association; Dr. Robert C. Markey, Bowling Green, Wood County Health commissioner; Dr. Margot D. Hartmann, Columbus, chief, Division of Child Hygiene, Ohio Department of Health; Dr. Wendell A. Butcher, Columbus, assistant commissioner, Ohio Department of Mental Hygiene and Correction, in charge of the state's program for mentally retarded children; Dr. Claire M. Ness, director, Cleveland Guidance Center.

Other members of the committee include educators, legislators and leaders in child and youth activities throughout the state. The chairman is Harry T. Sealy, a vice-president of the Cleveland Electric Illuminating Company.

The Washington meeting stems from the Mid-Century White House Conference held in 1950 for delegates from all states and territories.

The Ohio committee is expected to meet next year to discuss juvenile problems and to draft recommendations for the national conference.

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American College of Physicians, Ohio Regional Meeting, Veterans Administration Hospital, Cincinnati, January 22.

Chicago Medical Society, Annual Clinical Conference, Palmer House, Chicago, March 2-5.

Congress on Industrial Health of the AMA, Netherland Hilton Hotel, Cincinnati, February 16 and 17.

Congress on Medical Education and Licensure, Chicago, February 7-10.

Institute on Industrial Health, and Department of Ophthalmology, University of Cincinnati, Industrial Eye Problems, March 9-12.

Institute on Steroid Therapy, Ohio State University, January 8.

Ohio Orthopaedic Society, Meeting, Akron, April 10, 11.

Ohio Society of Internal Medicine, Netherland Hilton Hotel, Cincinnati, January 21.

Veterans Administration, Series of Clinical Courses, Wednesday Evenings, Cleveland.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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Subject: An Institute on Steroid Therapy which will be under the auspices of the Department of Medicine of Ohio State University School of Medicine.
Luncheon: To be served at the Ohio Union
Program: Morning Sessions:
Dr. Charles A. Doan will preside
Afternoon Sessions:
Dr. Philip S. Hench will preside
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Leon Goldman, M.D., Professor of Dermatology, University of Cincinnati, Cincinnati, Ohio
Dan M. Gordon, M.D. Assistant Professor of Ophthalmology, Cornell University, New York City
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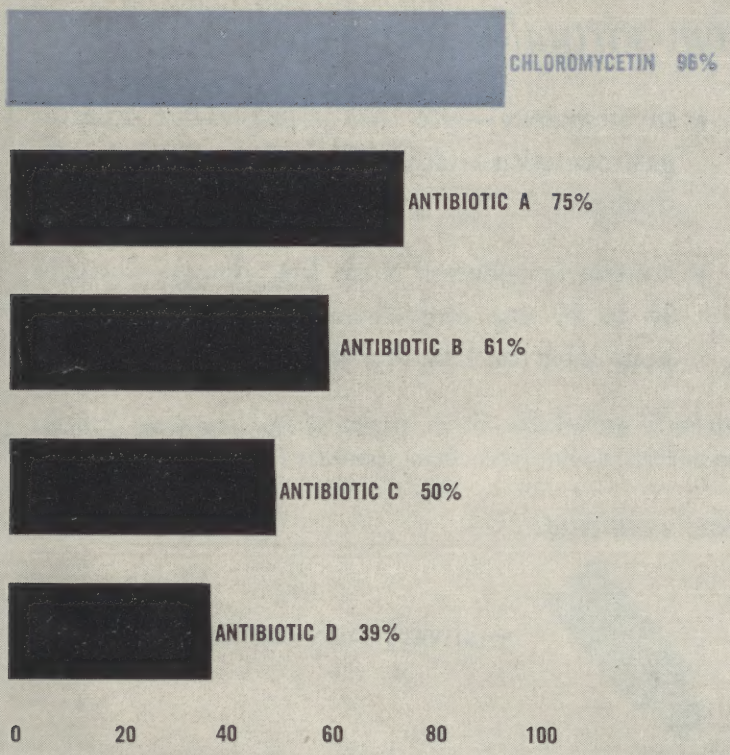
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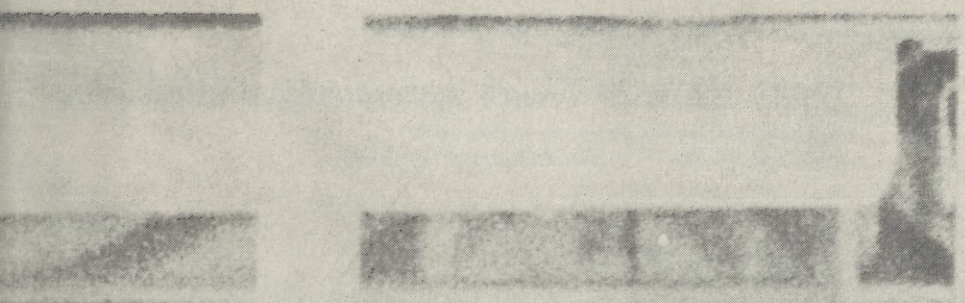
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